

1.1 ..... moves to amend H.F. No. 2930 as follows:

1.2 Delete everything after the enacting clause and insert:

1.3 "ARTICLE 1

1.4 DEPARTMENT OF HUMAN SERVICES HEALTH CARE

1.5 Section 1. Minnesota Statutes 2022, section 62A.045, is amended to read:

1.6 **62A.045 PAYMENTS ON BEHALF OF ENROLLEES IN GOVERNMENT**  
1.7 **HEALTH PROGRAMS.**

1.8 (a) As a condition of doing business in Minnesota or providing coverage to residents of  
1.9 Minnesota covered by this section, each health insurer shall comply with the requirements  
1.10 ~~of~~ for health insurers under the federal Deficit Reduction Act of 2005, Public Law 109-171  
1.11 and the federal Consolidated Appropriations Act of 2022, Public Law 117-103, including  
1.12 any federal regulations adopted under ~~that act~~ those acts, to the extent that ~~it imposes~~ they  
1.13 impose a requirement that applies in this state and that is not also required by the laws of  
1.14 this state. This section does not require compliance with any provision of the federal ~~act~~  
1.15 acts prior to the effective ~~date~~ dates provided for ~~that provision~~ those provisions in the  
1.16 federal ~~act~~ acts. The commissioner shall enforce this section.

1.17 For the purpose of this section, "health insurer" includes self-insured plans, group health  
1.18 plans (as defined in section 607(1) of the Employee Retirement Income Security Act of  
1.19 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or  
1.20 other parties that are by contract legally responsible to pay a claim for a health-care item  
1.21 or service for an individual receiving benefits under paragraph (b).

1.22 (b) No plan offered by a health insurer issued or renewed to provide coverage to a  
1.23 Minnesota resident shall contain any provision denying or reducing benefits because services  
1.24 are rendered to a person who is eligible for or receiving medical benefits pursuant to title

2.1 XIX of the Social Security Act (Medicaid) in this or any other state; chapter 256 or 256B;  
2.2 or services pursuant to section 252.27; 256L.01 to 256L.10; 260B.331, subdivision 2;  
2.3 260C.331, subdivision 2; or 393.07, subdivision 1 or 2. No health insurer providing benefits  
2.4 under plans covered by this section shall use eligibility for medical programs named in this  
2.5 section as an underwriting guideline or reason for nonacceptance of the risk.

2.6 (c) If payment for covered expenses has been made under state medical programs for  
2.7 health care items or services provided to an individual, and a third party has a legal liability  
2.8 to make payments, the rights of payment and appeal of an adverse coverage decision for  
2.9 the individual, or in the case of a child their responsible relative or caretaker, will be  
2.10 subrogated to the state agency. The state agency may assert its rights under this section  
2.11 within three years of the date the service was rendered. For purposes of this section, "state  
2.12 agency" includes prepaid health plans under contract with the commissioner according to  
2.13 sections 256B.69 and 256L.12; children's mental health collaboratives under section 245.493;  
2.14 demonstration projects for persons with disabilities under section 256B.77; nursing homes  
2.15 under the alternative payment demonstration project under section 256B.434; and  
2.16 county-based purchasing entities under section 256B.692.

2.17 (d) Notwithstanding any law to the contrary, when a person covered by a plan offered  
2.18 by a health insurer receives medical benefits according to any statute listed in this section,  
2.19 payment for covered services or notice of denial for services billed by the provider must be  
2.20 issued directly to the provider. If a person was receiving medical benefits through the  
2.21 Department of Human Services at the time a service was provided, the provider must indicate  
2.22 this benefit coverage on any claim forms submitted by the provider to the health insurer for  
2.23 those services. If the commissioner of human services notifies the health insurer that the  
2.24 commissioner has made payments to the provider, payment for benefits or notices of denials  
2.25 issued by the health insurer must be issued directly to the commissioner. Submission by the  
2.26 department to the health insurer of the claim on a Department of Human Services claim  
2.27 form is proper notice and shall be considered proof of payment of the claim to the provider  
2.28 and supersedes any contract requirements of the health insurer relating to the form of  
2.29 submission. Liability to the insured for coverage is satisfied to the extent that payments for  
2.30 those benefits are made by the health insurer to the provider or the commissioner as required  
2.31 by this section.

2.32 (e) When a state agency has acquired the rights of an individual eligible for medical  
2.33 programs named in this section and has health benefits coverage through a health insurer,  
2.34 the health insurer shall not impose requirements that are different from requirements  
2.35 applicable to an agent or assignee of any other individual covered.

3.1 (f) A health insurer must process a clean claim made by a state agency for covered  
3.2 expenses paid under state medical programs within 90 business days of the claim's  
3.3 submission. A health insurer must process all other claims made by a state agency for  
3.4 covered expenses paid under a state medical program within the timeline set forth in Code  
3.5 of Federal Regulations, title 42, section 447.45(d)(4).

3.6 (g) A health insurer may request a refund of a claim paid in error to the Department of  
3.7 Human Services within two years of the date the payment was made to the department. A  
3.8 request for a refund shall not be honored by the department if the health insurer makes the  
3.9 request after the time period has lapsed.

3.10 Sec. 2. Minnesota Statutes 2022, section 62A.673, subdivision 2, is amended to read:

3.11 Subd. 2. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision  
3.12 have the meanings given.

3.13 (b) "Distant site" means a site at which a health care provider is located while providing  
3.14 health care services or consultations by means of telehealth.

3.15 (c) "Health care provider" means a health care professional who is licensed or registered  
3.16 by the state to perform health care services within the provider's scope of practice and in  
3.17 accordance with state law. A health care provider includes a mental health professional  
3.18 under section 245I.04, subdivision 2; a mental health practitioner under section 245I.04,  
3.19 subdivision 4; a clinical trainee under section 245I.04, subdivision 6; a treatment coordinator  
3.20 under section 245G.11, subdivision 7; an alcohol and drug counselor under section 245G.11,  
3.21 subdivision 5; and a recovery peer under section 245G.11, subdivision 8.

3.22 (d) "Health carrier" has the meaning given in section 62A.011, subdivision 2.

3.23 (e) "Health plan" has the meaning given in section 62A.011, subdivision 3. Health plan  
3.24 includes dental plans as defined in section 62Q.76, subdivision 3, but does not include dental  
3.25 plans that provide indemnity-based benefits, regardless of expenses incurred, and are designed  
3.26 to pay benefits directly to the policy holder.

3.27 (f) "Originating site" means a site at which a patient is located at the time health care  
3.28 services are provided to the patient by means of telehealth. For purposes of store-and-forward  
3.29 technology, the originating site also means the location at which a health care provider  
3.30 transfers or transmits information to the distant site.

3.31 (g) "Store-and-forward technology" means the asynchronous electronic transfer or  
3.32 transmission of a patient's medical information or data from an originating site to a distant  
3.33 site for the purposes of diagnostic and therapeutic assistance in the care of a patient.

4.1 (h) "Telehealth" means the delivery of health care services or consultations through the  
4.2 use of real time two-way interactive audio and visual communications to provide or support  
4.3 health care delivery and facilitate the assessment, diagnosis, consultation, treatment,  
4.4 education, and care management of a patient's health care. Telehealth includes the application  
4.5 of secure video conferencing, store-and-forward technology, and synchronous interactions  
4.6 between a patient located at an originating site and a health care provider located at a distant  
4.7 site. Until July 1, ~~2023~~ 2025, telehealth also includes audio-only communication between  
4.8 a health care provider and a patient in accordance with subdivision 6, paragraph (b).  
4.9 Telehealth does not include communication between health care providers that consists  
4.10 solely of a telephone conversation, email, or facsimile transmission. Telehealth does not  
4.11 include communication between a health care provider and a patient that consists solely of  
4.12 an email or facsimile transmission. Telehealth does not include telemonitoring services as  
4.13 defined in paragraph (i).

4.14 (i) "Telemonitoring services" means the remote monitoring of clinical data related to  
4.15 the enrollee's vital signs or biometric data by a monitoring device or equipment that transmits  
4.16 the data electronically to a health care provider for analysis. Telemonitoring is intended to  
4.17 collect an enrollee's health-related data for the purpose of assisting a health care provider  
4.18 in assessing and monitoring the enrollee's medical condition or status.

4.19 Sec. 3. Minnesota Statutes 2020, section 256.01, is amended by adding a subdivision to  
4.20 read:

4.21 Subd. 43. **Education on contraceptive options.** The commissioner shall require hospitals  
4.22 and primary care providers serving medical assistance and MinnesotaCare enrollees to  
4.23 develop and implement protocols to provide these enrollees, when appropriate, with  
4.24 comprehensive and scientifically accurate information on the full range of contraceptive  
4.25 options, in a medically ethical, culturally competent, and noncoercive manner. The  
4.26 information provided must be designed to assist enrollees in identifying the contraceptive  
4.27 method that best meets their needs and the needs of their families. The protocol must specify  
4.28 the enrollee categories to which this requirement will be applied, the process to be used,  
4.29 and the information and resources to be provided. Hospitals and providers must make this  
4.30 protocol available to the commissioner upon request.

4.31 Sec. 4. Minnesota Statutes 2022, section 256.0471, subdivision 1, is amended to read:

4.32 Subdivision 1. **Qualifying overpayment.** Any overpayment for assistance granted under  
4.33 chapter 119B, the MFIP program formerly codified under sections 256.031 to 256.0361,

5.1 and the AFDC program formerly codified under sections 256.72 to 256.871; section 256.045,  
5.2 subdivision 10; chapters 256B for state-funded medical assistance, 256D, 256I, 256J, 256K,  
5.3 and 256L for state-funded MinnesotaCare; and the Supplemental Nutrition Assistance  
5.4 Program (SNAP), except agency error claims, become a judgment by operation of law 90  
5.5 days after the notice of overpayment is personally served upon the recipient in a manner  
5.6 that is sufficient under rule 4.03(a) of the Rules of Civil Procedure for district courts, or by  
5.7 certified mail, return receipt requested. This judgment shall be entitled to full faith and credit  
5.8 in this and any other state.

5.9 **EFFECTIVE DATE.** This section is effective July 1, 2023.

5.10 Sec. 5. Minnesota Statutes 2022, section 256.969, subdivision 2b, is amended to read:

5.11 Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November  
5.12 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according  
5.13 to the following:

5.14 (1) critical access hospitals as defined by Medicare shall be paid using a cost-based  
5.15 methodology;

5.16 (2) long-term hospitals as defined by Medicare shall be paid on a per diem methodology  
5.17 under subdivision 25;

5.18 (3) rehabilitation hospitals or units of hospitals that are recognized as rehabilitation  
5.19 distinct parts as defined by Medicare shall be paid according to the methodology under  
5.20 subdivision 12; and

5.21 (4) all other hospitals shall be paid on a diagnosis-related group (DRG) methodology.

5.22 (b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not  
5.23 be rebased, except that a Minnesota long-term hospital shall be rebased effective January  
5.24 1, 2011, based on its most recent Medicare cost report ending on or before September 1,  
5.25 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on  
5.26 December 31, 2010. For rate setting periods after November 1, 2014, in which the base  
5.27 years are updated, a Minnesota long-term hospital's base year shall remain within the same  
5.28 period as other hospitals.

5.29 (c) Effective for discharges occurring on and after November 1, 2014, payment rates  
5.30 for hospital inpatient services provided by hospitals located in Minnesota or the local trade  
5.31 area, except for the hospitals paid under the methodologies described in paragraph (a),  
5.32 clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a  
5.33 manner similar to Medicare. The base year or years for the rates effective November 1,

6.1 2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral,  
6.2 ensuring that the total aggregate payments under the rebased system are equal to the total  
6.3 aggregate payments that were made for the same number and types of services in the base  
6.4 year. Separate budget neutrality calculations shall be determined for payments made to  
6.5 critical access hospitals and payments made to hospitals paid under the DRG system. Only  
6.6 the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being  
6.7 rebased during the entire base period shall be incorporated into the budget neutrality  
6.8 calculation.

6.9 (d) For discharges occurring on or after November 1, 2014, through the next rebasing  
6.10 that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph  
6.11 (a), clause (4), shall include adjustments to the projected rates that result in no greater than  
6.12 a five percent increase or decrease from the base year payments for any hospital. Any  
6.13 adjustments to the rates made by the commissioner under this paragraph and paragraph (e)  
6.14 shall maintain budget neutrality as described in paragraph (c).

6.15 (e) For discharges occurring on or after November 1, 2014, the commissioner may make  
6.16 additional adjustments to the rebased rates, and when evaluating whether additional  
6.17 adjustments should be made, the commissioner shall consider the impact of the rates on the  
6.18 following:

6.19 (1) pediatric services;

6.20 (2) behavioral health services;

6.21 (3) trauma services as defined by the National Uniform Billing Committee;

6.22 (4) transplant services;

6.23 (5) obstetric services, newborn services, and behavioral health services provided by  
6.24 hospitals outside the seven-county metropolitan area;

6.25 (6) outlier admissions;

6.26 (7) low-volume providers; and

6.27 (8) services provided by small rural hospitals that are not critical access hospitals.

6.28 (f) Hospital payment rates established under paragraph (c) must incorporate the following:

6.29 (1) for hospitals paid under the DRG methodology, the base year payment rate per  
6.30 admission is standardized by the applicable Medicare wage index and adjusted by the  
6.31 hospital's disproportionate population adjustment;

7.1 (2) for critical access hospitals, payment rates for discharges between November 1, 2014,  
7.2 and June 30, 2015, shall be set to the same rate of payment that applied for discharges on  
7.3 October 31, 2014;

7.4 (3) the cost and charge data used to establish hospital payment rates must only reflect  
7.5 inpatient services covered by medical assistance; and

7.6 (4) in determining hospital payment rates for discharges occurring on or after the rate  
7.7 year beginning January 1, 2011, through December 31, 2012, the hospital payment rate per  
7.8 discharge shall be based on the cost-finding methods and allowable costs of the Medicare  
7.9 program in effect during the base year or years. In determining hospital payment rates for  
7.10 discharges in subsequent base years, the per discharge rates shall be based on the cost-finding  
7.11 methods and allowable costs of the Medicare program in effect during the base year or  
7.12 years.

7.13 (g) The commissioner shall validate the rates effective November 1, 2014, by applying  
7.14 the rates established under paragraph (c), and any adjustments made to the rates under  
7.15 paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the  
7.16 total aggregate payments for the same number and types of services under the rebased rates  
7.17 are equal to the total aggregate payments made during calendar year 2013.

7.18 (h) Effective for discharges occurring on or after July 1, 2017, and every two years  
7.19 thereafter, payment rates under this section shall be rebased to reflect only those changes  
7.20 in hospital costs between the existing base year or years and the next base year or years. In  
7.21 any year that inpatient claims volume falls below the threshold required to ensure a  
7.22 statistically valid sample of claims, the commissioner may combine claims data from two  
7.23 consecutive years to serve as the base year. Years in which inpatient claims volume is  
7.24 reduced or altered due to a pandemic or other public health emergency shall not be used as  
7.25 a base year or part of a base year if the base year includes more than one year. Changes in  
7.26 costs between base years shall be measured using the lower of the hospital cost index defined  
7.27 in subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per  
7.28 claim. The commissioner shall establish the base year for each rebasing period considering  
7.29 the most recent year or years for which filed Medicare cost reports are available, except  
7.30 that the base years for the rebasing effective July 1, 2023, are calendar years 2018 and 2019.  
7.31 The estimated change in the average payment per hospital discharge resulting from a  
7.32 scheduled rebasing must be calculated and made available to the legislature by January 15  
7.33 of each year in which rebasing is scheduled to occur, and must include by hospital the  
7.34 differential in payment rates compared to the individual hospital's costs.

8.1 (i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates  
8.2 for critical access hospitals located in Minnesota or the local trade area shall be determined  
8.3 using a new cost-based methodology. The commissioner shall establish within the  
8.4 methodology tiers of payment designed to promote efficiency and cost-effectiveness.  
8.5 Payment rates for hospitals under this paragraph shall be set at a level that does not exceed  
8.6 the total cost for critical access hospitals as reflected in base year cost reports. Until the  
8.7 next rebasing that occurs, the new methodology shall result in no greater than a five percent  
8.8 decrease from the base year payments for any hospital, except a hospital that had payments  
8.9 that were greater than 100 percent of the hospital's costs in the base year shall have their  
8.10 rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and  
8.11 after July 1, 2016, covered under this paragraph shall be increased by the inflation factor  
8.12 in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not  
8.13 be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the  
8.14 following criteria:

8.15 (1) hospitals that had payments at or below 80 percent of their costs in the base year  
8.16 shall have a rate set that equals 85 percent of their base year costs;

8.17 (2) hospitals that had payments that were above 80 percent, up to and including 90  
8.18 percent of their costs in the base year shall have a rate set that equals 95 percent of their  
8.19 base year costs; and

8.20 (3) hospitals that had payments that were above 90 percent of their costs in the base year  
8.21 shall have a rate set that equals 100 percent of their base year costs.

8.22 (j) The commissioner may refine the payment tiers and criteria for critical access hospitals  
8.23 to coincide with the next rebasing under paragraph (h). The factors used to develop the new  
8.24 methodology may include, but are not limited to:

8.25 (1) the ratio between the hospital's costs for treating medical assistance patients and the  
8.26 hospital's charges to the medical assistance program;

8.27 (2) the ratio between the hospital's costs for treating medical assistance patients and the  
8.28 hospital's payments received from the medical assistance program for the care of medical  
8.29 assistance patients;

8.30 (3) the ratio between the hospital's charges to the medical assistance program and the  
8.31 hospital's payments received from the medical assistance program for the care of medical  
8.32 assistance patients;

8.33 (4) the statewide average increases in the ratios identified in clauses (1), (2), and (3);

9.1 (5) the proportion of that hospital's costs that are administrative and trends in  
9.2 administrative costs; and

9.3 (6) geographic location.

9.4 **EFFECTIVE DATE.** This section is effective July 1, 2023.

9.5 Sec. 6. Minnesota Statutes 2022, section 256.969, subdivision 25, is amended to read:

9.6 Subd. 25. **Long-term hospital rates.** (a) Long-term hospitals shall be paid on a per diem  
9.7 basis.

9.8 (b) For admissions occurring on or after April 1, 1995, a long-term hospital as designated  
9.9 by Medicare that does not have admissions in the base year shall have inpatient rates  
9.10 established at the average of other hospitals with the same designation. For subsequent  
9.11 rate-setting periods in which base years are updated, the hospital's base year shall be the  
9.12 first Medicare cost report filed with the long-term hospital designation and shall remain in  
9.13 effect until it falls within the same period as other hospitals.

9.14 (c) For admissions occurring on or after July 1, 2023, long-term hospitals must be paid  
9.15 the higher of a per diem amount computed using the methodology described in subdivision  
9.16 2b, paragraph (i), or the per diem rate as of July 1, 2021.

9.17 **EFFECTIVE DATE.** This section is effective July 1, 2023.

9.18 Sec. 7. Minnesota Statutes 2022, section 256.969, is amended by adding a subdivision to  
9.19 read:

9.20 Subd. 31. **Long-acting reversible contraceptives.** (a) The commissioner must provide  
9.21 separate reimbursement to hospitals for long-acting reversible contraceptives provided  
9.22 immediately postpartum in the inpatient hospital setting. This payment must be in addition  
9.23 to the diagnostic related group reimbursement for labor and delivery.

9.24 (b) The commissioner must require managed care and county-based purchasing plans  
9.25 to comply with this subdivision when providing services to medical assistance enrollees.

9.26 **EFFECTIVE DATE.** This section is effective January 1, 2024.

9.27 Sec. 8. Minnesota Statutes 2022, section 256B.04, subdivision 14, is amended to read:

9.28 Subd. 14. **Competitive bidding.** (a) When determined to be effective, economical, and  
9.29 feasible, the commissioner may utilize volume purchase through competitive bidding and

10.1 negotiation under the provisions of chapter 16C, to provide items under the medical assistance  
10.2 program including but not limited to the following:

10.3 (1) eyeglasses;

10.4 (2) oxygen. The commissioner shall provide for oxygen needed in an emergency situation  
10.5 on a short-term basis, until the vendor can obtain the necessary supply from the contract  
10.6 dealer;

10.7 (3) hearing aids and supplies;

10.8 (4) durable medical equipment, including but not limited to:

10.9 (i) hospital beds;

10.10 (ii) commodes;

10.11 (iii) glide-about chairs;

10.12 (iv) patient lift apparatus;

10.13 (v) wheelchairs and accessories;

10.14 (vi) oxygen administration equipment;

10.15 (vii) respiratory therapy equipment;

10.16 (viii) electronic diagnostic, therapeutic and life-support systems; and

10.17 (ix) allergen-reducing products as described in section 256B.0625, subdivision 67,  
10.18 paragraph (c) or (d);

10.19 (5) nonemergency medical transportation level of need determinations, disbursement of  
10.20 public transportation passes and tokens, and volunteer and recipient mileage and parking  
10.21 reimbursements; ~~and~~

10.22 (6) drugs; and

10.23 (7) quitline services as described in section 256B.0625, subdivision 68, paragraph (c).

10.24 (b) Rate changes and recipient cost-sharing under this chapter and chapter 256L do not  
10.25 affect contract payments under this subdivision unless specifically identified.

10.26 (c) The commissioner may not utilize volume purchase through competitive bidding  
10.27 and negotiation under the provisions of chapter 16C for special transportation services or  
10.28 incontinence products and related supplies.

11.1 Sec. 9. Minnesota Statutes 2022, section 256B.055, subdivision 17, is amended to read:

11.2 Subd. 17. **Adults who were in foster care at the age of 18.** (a) Medical assistance may  
 11.3 be paid for a person under 26 years of age who was in foster care under the commissioner's  
 11.4 responsibility on the date of attaining 18 years of age, and who was enrolled in medical  
 11.5 assistance under the state plan or a waiver of the plan while in foster care, in accordance  
 11.6 with section 2004 of the Affordable Care Act.

11.7 (b) Beginning July 1, 2023, medical assistance may be paid for a person under 26 years  
 11.8 of age who was in foster care on the date of attaining 18 years of age and enrolled in another  
 11.9 state's Medicaid program while in foster care in accordance with the Substance Use-Disorder  
 11.10 Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities  
 11.11 Act of 2018. Public Law 115-271, section 1002.

11.12 **EFFECTIVE DATE.** This section is effective the day following final enactment.

11.13 Sec. 10. Minnesota Statutes 2022, section 256B.0625, subdivision 9, is amended to read:

11.14 Subd. 9. **Dental services.** (a) Medical assistance covers medically necessary dental  
 11.15 services.

11.16 ~~(b) Medical assistance dental coverage for nonpregnant adults is limited to the following~~  
 11.17 ~~services:~~

11.18 ~~(1) comprehensive exams, limited to once every five years;~~

11.19 ~~(2) periodic exams, limited to one per year;~~

11.20 ~~(3) limited exams;~~

11.21 ~~(4) bitewing x-rays, limited to one per year;~~

11.22 ~~(5) periapical x-rays;~~

11.23 ~~(6) panoramic x-rays, limited to one every five years except (1) when medically necessary~~  
 11.24 ~~for the diagnosis and follow-up of oral and maxillofacial pathology and trauma or (2) once~~  
 11.25 ~~every two years for patients who cannot cooperate for intraoral film due to a developmental~~  
 11.26 ~~disability or medical condition that does not allow for intraoral film placement;~~

11.27 ~~(7) prophylaxis, limited to one per year;~~

11.28 ~~(8) application of fluoride varnish, limited to one per year;~~

11.29 ~~(9) posterior fillings, all at the amalgam rate;~~

11.30 ~~(10) anterior fillings;~~

- 12.1 ~~(11) endodontics, limited to root canals on the anterior and premolars only;~~
- 12.2 ~~(12) removable prostheses, each dental arch limited to one every six years;~~
- 12.3 ~~(13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;~~
- 12.4 ~~(14) palliative treatment and sedative fillings for relief of pain;~~
- 12.5 ~~(15) full-mouth debridement, limited to one every five years; and~~
- 12.6 ~~(16) nonsurgical treatment for periodontal disease, including scaling and root planing~~
- 12.7 ~~once every two years for each quadrant, and routine periodontal maintenance procedures.~~
- 12.8 ~~(e) In addition to the services specified in paragraph (b), medical assistance covers the~~
- 12.9 ~~following services for adults, if provided in an outpatient hospital setting or freestanding~~
- 12.10 ~~ambulatory surgical center as part of outpatient dental surgery:~~
- 12.11 ~~(1) periodontics, limited to periodontal scaling and root planing once every two years;~~
- 12.12 ~~(2) general anesthesia; and~~
- 12.13 ~~(3) full-mouth survey once every five years.~~
- 12.14 ~~(d) Medical assistance covers medically necessary dental services for children and~~
- 12.15 ~~pregnant women. The following guidelines apply:~~
- 12.16 (1) posterior fillings are paid at the amalgam rate;
- 12.17 (2) application of sealants are covered once every five years per permanent molar for
- 12.18 ~~children only;~~
- 12.19 (3) application of fluoride varnish is covered once every six months; and
- 12.20 (4) orthodontia is eligible for coverage for children only.
- 12.21 ~~(e) (b)~~ In addition to the services specified in ~~paragraphs (b) and (e)~~ paragraph (a),
- 12.22 medical assistance covers the following services for adults:
- 12.23 (1) house calls or extended care facility calls for on-site delivery of covered services;
- 12.24 (2) behavioral management when additional staff time is required to accommodate
- 12.25 behavioral challenges and sedation is not used;
- 12.26 (3) oral or IV sedation, if the covered dental service cannot be performed safely without
- 12.27 it or would otherwise require the service to be performed under general anesthesia in a
- 12.28 hospital or surgical center; and
- 12.29 (4) prophylaxis, in accordance with an appropriate individualized treatment plan, but
- 12.30 no more than four times per year.

13.1       ~~(f)~~ (c) The commissioner shall not require prior authorization for the services included  
13.2 in paragraph ~~(e)~~ (b), clauses (1) to (3), and shall prohibit managed care and county-based  
13.3 purchasing plans from requiring prior authorization for the services included in paragraph  
13.4 ~~(e)~~ (b), clauses (1) to (3), when provided under sections 256B.69, 256B.692, and 256L.12.

13.5       **EFFECTIVE DATE.** This section is effective January 1, 2024, or upon federal approval,  
13.6 whichever is later.

13.7       Sec. 11. Minnesota Statutes 2022, section 256B.0625, subdivision 13c, is amended to  
13.8 read:

13.9       Subd. 13c. **Formulary Committee.** The commissioner, after receiving recommendations  
13.10 from professional medical associations and professional pharmacy associations, and consumer  
13.11 groups shall designate a Formulary Committee to carry out duties as described in subdivisions  
13.12 13 to 13g. The Formulary Committee shall be comprised of ~~four~~ at least five licensed  
13.13 physicians actively engaged in the practice of medicine in Minnesota, one of whom ~~must~~  
13.14 ~~be actively engaged in the treatment of persons with mental illness~~ is an actively practicing  
13.15 psychiatrist, one of whom specializes in the diagnosis and treatment of rare diseases, one  
13.16 of whom specializes in pediatrics, and one of whom actively treats persons with disabilities;  
13.17 at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota,  
13.18 one of whom practices outside the metropolitan counties listed in section 473.121, subdivision  
13.19 4, one of whom practices in the metropolitan counties listed in section 473.121, subdivision  
13.20 4, and one of whom is a practicing hospital pharmacist; and one at least four consumer  
13.21 ~~representative~~ representatives, all of whom must have a personal or professional connection  
13.22 to medical assistance; and one representative designated by the Minnesota Rare Disease  
13.23 Advisory Council established under section 256.4835; the remainder to be made up of health  
13.24 care professionals who are licensed in their field and have recognized knowledge in the  
13.25 clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs.  
13.26 Members of the Formulary Committee shall not be employed by the Department of Human  
13.27 Services, but the committee shall be staffed by an employee of the department who shall  
13.28 serve as an ex officio, nonvoting member of the committee. The department's medical  
13.29 director shall also serve as an ex officio, nonvoting member for the committee. Committee  
13.30 members shall serve three-year terms and may be reappointed by the commissioner. The  
13.31 Formulary Committee shall meet at least ~~twice~~ per year. The commissioner may require  
13.32 more frequent Formulary Committee meetings as needed. An honorarium of \$100 per  
13.33 meeting and reimbursement for mileage shall be paid to each committee member in  
13.34 attendance. Notwithstanding section 15.059, subdivision 6, the Formulary Committee expires  
13.35 June 30, 2023 does not expire.

14.1 Sec. 12. Minnesota Statutes 2022, section 256B.0625, subdivision 13e, is amended to  
14.2 read:

14.3 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall  
14.4 be the lower of the ingredient costs of the drugs plus the professional dispensing fee; or the  
14.5 usual and customary price charged to the public. The usual and customary price means the  
14.6 lowest price charged by the provider to a patient who pays for the prescription by cash,  
14.7 check, or charge account and includes prices the pharmacy charges to a patient enrolled in  
14.8 a prescription savings club or prescription discount club administered by the pharmacy or  
14.9 pharmacy chain. The amount of payment basis must be reduced to reflect all discount  
14.10 amounts applied to the charge by any third-party provider/insurer agreement or contract for  
14.11 submitted charges to medical assistance programs. The net submitted charge may not be  
14.12 greater than the patient liability for the service. The professional dispensing fee shall be  
14.13 \$10.77 for prescriptions filled with legend drugs meeting the definition of "covered outpatient  
14.14 drugs" according to United States Code, title 42, section 1396r-8(k)(2). The dispensing fee  
14.15 for intravenous solutions that must be compounded by the pharmacist shall be \$10.77 per  
14.16 claim. The professional dispensing fee for prescriptions filled with over-the-counter drugs  
14.17 meeting the definition of covered outpatient drugs shall be \$10.77 for dispensed quantities  
14.18 equal to or greater than the number of units contained in the manufacturer's original package.  
14.19 The professional dispensing fee shall be prorated based on the percentage of the package  
14.20 dispensed when the pharmacy dispenses a quantity less than the number of units contained  
14.21 in the manufacturer's original package. The pharmacy dispensing fee for prescribed  
14.22 over-the-counter drugs not meeting the definition of covered outpatient drugs shall be \$3.65  
14.23 for quantities equal to or greater than the number of units contained in the manufacturer's  
14.24 original package and shall be prorated based on the percentage of the package dispensed  
14.25 when the pharmacy dispenses a quantity less than the number of units contained in the  
14.26 manufacturer's original package. The National Average Drug Acquisition Cost (NADAC)  
14.27 shall be used to determine the ingredient cost of a drug. For drugs for which a NADAC is  
14.28 not reported, the commissioner shall estimate the ingredient cost at the wholesale acquisition  
14.29 cost minus two percent. The ingredient cost of a drug for a provider participating in the  
14.30 federal 340B Drug Pricing Program shall be either the 340B Drug Pricing Program ceiling  
14.31 price established by the Health Resources and Services Administration or NADAC,  
14.32 whichever is lower. Wholesale acquisition cost is defined as the manufacturer's list price  
14.33 for a drug or biological to wholesalers or direct purchasers in the United States, not including  
14.34 prompt pay or other discounts, rebates, or reductions in price, for the most recent month for  
14.35 which information is available, as reported in wholesale price guides or other publications  
14.36 of drug or biological pricing data. The maximum allowable cost of a multisource drug may

15.1 be set by the commissioner and it shall be comparable to the actual acquisition cost of the  
15.2 drug product and no higher than the NADAC of the generic product. Establishment of the  
15.3 amount of payment for drugs shall not be subject to the requirements of the Administrative  
15.4 Procedure Act.

15.5 (b) Pharmacies dispensing prescriptions to residents of long-term care facilities using  
15.6 an automated drug distribution system meeting the requirements of section 151.58, or a  
15.7 packaging system meeting the packaging standards set forth in Minnesota Rules, part  
15.8 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ  
15.9 retrospective billing for prescription drugs dispensed to long-term care facility residents. A  
15.10 retrospectively billing pharmacy must submit a claim only for the quantity of medication  
15.11 used by the enrolled recipient during the defined billing period. A retrospectively billing  
15.12 pharmacy must use a billing period not less than one calendar month or 30 days.

15.13 (c) A pharmacy provider using packaging that meets the standards set forth in Minnesota  
15.14 Rules, part 6800.2700, is required to credit the department for the actual acquisition cost  
15.15 of all unused drugs that are eligible for reuse, unless the pharmacy is using retrospective  
15.16 billing. The commissioner may permit the drug clozapine to be dispensed in a quantity that  
15.17 is less than a 30-day supply.

15.18 (d) If a pharmacy dispenses a multisource drug, the ingredient cost shall be the NADAC  
15.19 of the generic product or the maximum allowable cost established by the commissioner  
15.20 unless prior authorization for the brand name product has been granted according to the  
15.21 criteria established by the Drug Formulary Committee as required by subdivision 13f,  
15.22 paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in  
15.23 a manner consistent with section 151.21, subdivision 2.

15.24 (e) The basis for determining the amount of payment for drugs administered in an  
15.25 outpatient setting shall be the lower of the usual and customary cost submitted by the  
15.26 provider, 106 percent of the average sales price as determined by the United States  
15.27 Department of Health and Human Services pursuant to title XVIII, section 1847a of the  
15.28 federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost  
15.29 set by the commissioner. If average sales price is unavailable, the amount of payment must  
15.30 be lower of the usual and customary cost submitted by the provider, the wholesale acquisition  
15.31 cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner.  
15.32 The commissioner shall discount the payment rate for drugs obtained through the federal  
15.33 340B Drug Pricing Program by 28.6 percent. The payment for drugs administered in an  
15.34 outpatient setting shall be made to the administering facility or practitioner. A retail or

16.1 specialty pharmacy dispensing a drug for administration in an outpatient setting is not  
16.2 eligible for direct reimbursement.

16.3 (f) The commissioner may establish maximum allowable cost rates for specialty pharmacy  
16.4 products that are lower than the ingredient cost formulas specified in paragraph (a). The  
16.5 commissioner may require individuals enrolled in the health care programs administered  
16.6 by the department to obtain specialty pharmacy products from providers with whom the  
16.7 commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are  
16.8 defined as those used by a small number of recipients or recipients with complex and chronic  
16.9 diseases that require expensive and challenging drug regimens. Examples of these conditions  
16.10 include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C,  
16.11 growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of  
16.12 cancer. Specialty pharmaceutical products include injectable and infusion therapies,  
16.13 biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that  
16.14 require complex care. The commissioner shall consult with the Formulary Committee to  
16.15 develop a list of specialty pharmacy products subject to maximum allowable cost  
16.16 reimbursement. In consulting with the Formulary Committee in developing this list, the  
16.17 commissioner shall take into consideration the population served by specialty pharmacy  
16.18 products, the current delivery system and standard of care in the state, and access to care  
16.19 issues. The commissioner shall have the discretion to adjust the maximum allowable cost  
16.20 to prevent access to care issues.

16.21 (g) Home infusion therapy services provided by home infusion therapy pharmacies must  
16.22 be paid at rates according to subdivision 8d.

16.23 (h) The commissioner shall contract with a vendor to conduct a cost of dispensing survey  
16.24 for all pharmacies that are physically located in the state of Minnesota that dispense outpatient  
16.25 drugs under medical assistance. The commissioner shall ensure that the vendor has prior  
16.26 experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the  
16.27 department to dispense outpatient prescription drugs to fee-for-service members must  
16.28 respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under  
16.29 section 256B.064 for failure to respond. The commissioner shall require the vendor to  
16.30 measure a single statewide cost of dispensing for specialty prescription drugs and a single  
16.31 statewide cost of dispensing for nonspecialty prescription drugs for all responding pharmacies  
16.32 to measure the mean, mean weighted by total prescription volume, mean weighted by  
16.33 medical assistance prescription volume, median, median weighted by total prescription  
16.34 volume, and median weighted by total medical assistance prescription volume. The  
16.35 commissioner shall post a copy of the final cost of dispensing survey report on the

17.1 department's website. The initial survey must be completed no later than January 1, 2021,  
17.2 and repeated every three years. The commissioner shall provide a summary of the results  
17.3 of each cost of dispensing survey and provide recommendations for any changes to the  
17.4 dispensing fee to the chairs and ranking members of the legislative committees with  
17.5 jurisdiction over medical assistance pharmacy reimbursement. Notwithstanding section  
17.6 256.01, subdivision 42, this paragraph does not expire.

17.7 (i) The commissioner shall increase the ingredient cost reimbursement calculated in  
17.8 paragraphs (a) and (f) by 1.8 percent for prescription and nonprescription drugs subject to  
17.9 the wholesale drug distributor tax under section 295.52.

17.10 **EFFECTIVE DATE.** This section is effective the day following final enactment.

17.11 Sec. 13. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision  
17.12 to read:

17.13 Subd. 13k. **Value-based purchasing arrangements.** (a) The commissioner may enter  
17.14 into a value-based purchasing arrangement for the medical assistance or MinnesotaCare  
17.15 program by written arrangement with a drug manufacturer based on agreed-upon metrics.  
17.16 The commissioner may enter into a contract with a vendor for the purpose of participating  
17.17 in a value-based purchasing arrangement. A value-based purchasing arrangement may  
17.18 include a rebate, a discount, a price reduction, risk sharing, a reimbursement, a guarantee,  
17.19 shared savings payments, withholds, a bonus, or any other thing of value. A value-based  
17.20 purchasing arrangement must provide the same amount or more of a value or discount in  
17.21 the aggregate as would claiming the mandatory federal drug rebate under the Federal Social  
17.22 Security Act, section 1927.

17.23 (b) Nothing in this section shall be interpreted as requiring a drug manufacturer or the  
17.24 commissioner to enter into an arrangement as described in paragraph (a).

17.25 (c) Nothing in this section shall be interpreted as altering or modifying medical assistance  
17.26 coverage requirements under the federal Social Security Act, section 1927.

17.27 (d) If the commissioner determines that a state plan amendment is necessary for  
17.28 implementation before implementing a value-based purchasing arrangement, the  
17.29 commissioner shall request the amendment and may delay implementing this provision  
17.30 until the amendment is approved.

17.31 **EFFECTIVE DATE.** This section is effective July 1, 2023.

18.1 Sec. 14. Minnesota Statutes 2022, section 256B.0625, subdivision 16, is amended to read:

18.2 Subd. 16. **Abortion services.** Medical assistance covers abortion services, ~~but only if~~  
18.3 ~~one of the following conditions is met:~~ determined to be medically necessary by the treating  
18.4 provider and delivered in accordance with all applicable Minnesota laws.

18.5 ~~(a) The abortion is a medical necessity. "Medical necessity" means (1) the signed written~~  
18.6 ~~statement of two physicians indicating the abortion is medically necessary to prevent the~~  
18.7 ~~death of the mother, and (2) the patient has given her consent to the abortion in writing~~  
18.8 ~~unless the patient is physically or legally incapable of providing informed consent to the~~  
18.9 ~~procedure, in which case consent will be given as otherwise provided by law;~~

18.10 ~~(b) The pregnancy is the result of criminal sexual conduct as defined in section 609.342,~~  
18.11 ~~subdivision 1, clauses (a), (b), (c)(i) and (ii), and (e), and subdivision 1a, clauses (a), (b),~~  
18.12 ~~(c)(i) and (ii), and (d), and the incident is reported within 48 hours after the incident occurs~~  
18.13 ~~to a valid law enforcement agency for investigation, unless the victim is physically unable~~  
18.14 ~~to report the criminal sexual conduct, in which case the report shall be made within 48 hours~~  
18.15 ~~after the victim becomes physically able to report the criminal sexual conduct; or~~

18.16 ~~(c) The pregnancy is the result of incest, but only if the incident and relative are reported~~  
18.17 ~~to a valid law enforcement agency for investigation prior to the abortion.~~

18.18 **EFFECTIVE DATE.** This section is effective the day following final enactment.

18.19 Sec. 15. Minnesota Statutes 2022, section 256B.0625, subdivision 22, is amended to read:

18.20 Subd. 22. **Hospice care.** Medical assistance covers hospice care services under Public  
18.21 Law 99-272, section 9505, to the extent authorized by rule, except that a recipient age 21  
18.22 or under who elects to receive hospice services does not waive coverage for services that  
18.23 are related to the treatment of the condition for which a diagnosis of terminal illness has  
18.24 been made. Hospice respite and end-of-life care under subdivision 22a are not hospice care  
18.25 services under this subdivision.

18.26 Sec. 16. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision  
18.27 to read:

18.28 Subd. 22a. **Residential hospice facility; hospice respite and end-of-life care for**  
18.29 **children.** (a) Medical assistance covers hospice respite and end-of-life care if the care is  
18.30 for recipients age 21 or under who elect to receive hospice care delivered in a facility that  
18.31 is licensed under sections 144A.75 to 144A.755 and that is a residential hospice facility

19.1 under section 144A.75, subdivision 13, paragraph (a). Hospice care services under  
19.2 subdivision 22 are not hospice respite or end-of-life care under this subdivision.

19.3 (b) The payment rates for coverage under this subdivision must be 100 percent of the  
19.4 Medicare rate for continuous home care hospice services as published in the Centers for  
19.5 Medicare and Medicaid Services annual final rule updating payments and policies for hospice  
19.6 care. The commissioner must seek to obtain federal financial participation for payment for  
19.7 hospice respite and end-of-life care under this subdivision. Payment must be made using  
19.8 state-only funds, if federal financial participation is not obtained. Payment for hospice  
19.9 respite and end-of-life care must be paid to the residential hospice facility and are not  
19.10 included in any limit or cap amount applicable to hospice services payments to the elected  
19.11 hospice services provider.

19.12 (c) Certification of the residential hospice facility by the federal Medicare program must  
19.13 not be a requirement of medical assistance payment for hospice respite and end-of-life care  
19.14 under this subdivision.

19.15 Sec. 17. Minnesota Statutes 2022, section 256B.0625, subdivision 28b, is amended to  
19.16 read:

19.17 Subd. 28b. **Doula services.** Medical assistance covers doula services provided by a  
19.18 certified doula as defined in section 148.995, subdivision 2, of the mother's choice. For  
19.19 purposes of this section, "doula services" means childbirth education and support services,  
19.20 including emotional and physical support provided during pregnancy, labor, birth, and  
19.21 postpartum. The commissioner shall enroll doula agencies and individual treating doulas  
19.22 to provide direct reimbursement.

19.23 **EFFECTIVE DATE.** This section is effective January 1, 2024, or upon federal approval,  
19.24 whichever is later. The commissioner of human services shall notify the revisor of statutes  
19.25 when federal approval is obtained.

19.26 Sec. 18. Minnesota Statutes 2022, section 256B.0625, subdivision 30, is amended to read:

19.27 Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services,  
19.28 federally qualified health center services, nonprofit community health clinic services, and  
19.29 public health clinic services. Rural health clinic services and federally qualified health center  
19.30 services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and  
19.31 (C). Payment for rural health clinic and federally qualified health center services shall be  
19.32 made according to applicable federal law and regulation.

20.1 (b) A federally qualified health center (FQHC) that is beginning initial operation shall  
20.2 submit an estimate of budgeted costs and visits for the initial reporting period in the form  
20.3 and detail required by the commissioner. An FQHC that is already in operation shall submit  
20.4 an initial report using actual costs and visits for the initial reporting period. Within 90 days  
20.5 of the end of its reporting period, an FQHC shall submit, in the form and detail required by  
20.6 the commissioner, a report of its operations, including allowable costs actually incurred for  
20.7 the period and the actual number of visits for services furnished during the period, and other  
20.8 information required by the commissioner. FQHCs that file Medicare cost reports shall  
20.9 provide the commissioner with a copy of the most recent Medicare cost report filed with  
20.10 the Medicare program intermediary for the reporting year which support the costs claimed  
20.11 on their cost report to the state.

20.12 (c) In order to continue cost-based payment under the medical assistance program  
20.13 according to paragraphs (a) and (b), an FQHC or rural health clinic must apply for designation  
20.14 as an essential community provider within six months of final adoption of rules by the  
20.15 Department of Health according to section 62Q.19, subdivision 7. For those FQHCs and  
20.16 rural health clinics that have applied for essential community provider status within the  
20.17 six-month time prescribed, medical assistance payments will continue to be made according  
20.18 to paragraphs (a) and (b) for the first three years after application. For FQHCs and rural  
20.19 health clinics that either do not apply within the time specified above or who have had  
20.20 essential community provider status for three years, medical assistance payments for health  
20.21 services provided by these entities shall be according to the same rates and conditions  
20.22 applicable to the same service provided by health care providers that are not FQHCs or rural  
20.23 health clinics.

20.24 (d) Effective July 1, 1999, the provisions of paragraph (c) requiring an FQHC or a rural  
20.25 health clinic to make application for an essential community provider designation in order  
20.26 to have cost-based payments made according to paragraphs (a) and (b) no longer apply.

20.27 (e) Effective January 1, 2000, payments made according to paragraphs (a) and (b) shall  
20.28 be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

20.29 (f) Effective January 1, 2001, through December 31, 2020, each FQHC and rural health  
20.30 clinic may elect to be paid either under the prospective payment system established in United  
20.31 States Code, title 42, section 1396a(aa), or under an alternative payment methodology  
20.32 consistent with the requirements of United States Code, title 42, section 1396a(aa), and  
20.33 approved by the Centers for Medicare and Medicaid Services. The alternative payment  
20.34 methodology shall be 100 percent of cost as determined according to Medicare cost  
20.35 principles.

21.1 (g) Effective for services provided on or after January 1, 2021, all claims for payment  
21.2 of clinic services provided by FQHCs and rural health clinics shall be paid by the  
21.3 commissioner, according to an annual election by the FQHC or rural health clinic, under  
21.4 the current prospective payment system described in paragraph (f) or the alternative payment  
21.5 methodology described in paragraph (l).

21.6 (h) For purposes of this section, "nonprofit community clinic" is a clinic that:

21.7 (1) has nonprofit status as specified in chapter 317A;

21.8 (2) has tax exempt status as provided in Internal Revenue Code, section 501(c)(3);

21.9 (3) is established to provide health services to low-income population groups, uninsured,  
21.10 high-risk and special needs populations, underserved and other special needs populations;

21.11 (4) employs professional staff at least one-half of which are familiar with the cultural  
21.12 background of their clients;

21.13 (5) charges for services on a sliding fee scale designed to provide assistance to  
21.14 low-income clients based on current poverty income guidelines and family size; and

21.15 (6) does not restrict access or services because of a client's financial limitations or public  
21.16 assistance status and provides no-cost care as needed.

21.17 (i) Effective for services provided on or after January 1, 2015, all claims for payment  
21.18 of clinic services provided by FQHCs and rural health clinics shall be paid by the  
21.19 commissioner. the commissioner shall determine the most feasible method for paying claims  
21.20 from the following options:

21.21 (1) FQHCs and rural health clinics submit claims directly to the commissioner for  
21.22 payment, and the commissioner provides claims information for recipients enrolled in a  
21.23 managed care or county-based purchasing plan to the plan, on a regular basis; or

21.24 (2) FQHCs and rural health clinics submit claims for recipients enrolled in a managed  
21.25 care or county-based purchasing plan to the plan, and those claims are submitted by the  
21.26 plan to the commissioner for payment to the clinic.

21.27 (j) For clinic services provided prior to January 1, 2015, the commissioner shall calculate  
21.28 and pay monthly the proposed managed care supplemental payments to clinics, and clinics  
21.29 shall conduct a timely review of the payment calculation data in order to finalize all  
21.30 supplemental payments in accordance with federal law. Any issues arising from a clinic's  
21.31 review must be reported to the commissioner by January 1, 2017. Upon final agreement  
21.32 between the commissioner and a clinic on issues identified under this subdivision, and in

22.1 accordance with United States Code, title 42, section 1396a(bb), no supplemental payments  
22.2 for managed care plan or county-based purchasing plan claims for services provided prior  
22.3 to January 1, 2015, shall be made after June 30, 2017. If the commissioner and clinics are  
22.4 unable to resolve issues under this subdivision, the parties shall submit the dispute to the  
22.5 arbitration process under section 14.57.

22.6 (k) The commissioner shall seek a federal waiver, authorized under section 1115 of the  
22.7 Social Security Act, to obtain federal financial participation at the 100 percent federal  
22.8 matching percentage available to facilities of the Indian Health Service or tribal organization  
22.9 in accordance with section 1905(b) of the Social Security Act for expenditures made to  
22.10 organizations dually certified under Title V of the Indian Health Care Improvement Act,  
22.11 Public Law 94-437, and as a federally qualified health center under paragraph (a) that  
22.12 provides services to American Indian and Alaskan Native individuals eligible for services  
22.13 under this subdivision.

22.14 (l) All claims for payment of clinic services provided by FQHCs and rural health clinics,  
22.15 that have elected to be paid under this paragraph, shall be paid by the commissioner according  
22.16 to the following requirements:

22.17 (1) the commissioner shall establish a single medical and single dental organization  
22.18 encounter rate for each FQHC and rural health clinic when applicable;

22.19 (2) each FQHC and rural health clinic is eligible for same day reimbursement of one  
22.20 medical and one dental organization encounter rate if eligible medical and dental visits are  
22.21 provided on the same day;

22.22 (3) the commissioner shall reimburse FQHCs and rural health clinics, in accordance  
22.23 with current applicable Medicare cost principles, their allowable costs, including direct  
22.24 patient care costs and patient-related support services. Nonallowable costs include, but are  
22.25 not limited to:

22.26 (i) general social services and administrative costs;

22.27 (ii) retail pharmacy;

22.28 (iii) patient incentives, food, housing assistance, and utility assistance;

22.29 (iv) external lab and x-ray;

22.30 (v) navigation services;

22.31 (vi) health care taxes;

22.32 (vii) advertising, public relations, and marketing;

- 23.1 (viii) office entertainment costs, food, alcohol, and gifts;
- 23.2 (ix) contributions and donations;
- 23.3 (x) bad debts or losses on awards or contracts;
- 23.4 (xi) fines, penalties, damages, or other settlements;
- 23.5 (xii) fundraising, investment management, and associated administrative costs;
- 23.6 (xiii) research and associated administrative costs;
- 23.7 (xiv) nonpaid workers;
- 23.8 (xv) lobbying;
- 23.9 (xvi) scholarships and student aid; and
- 23.10 (xvii) nonmedical assistance covered services;
- 23.11 (4) the commissioner shall review the list of nonallowable costs in the years between
- 23.12 the rebasing process established in clause (5), in consultation with the Minnesota Association
- 23.13 of Community Health Centers, FQHCs, and rural health clinics. The commissioner shall
- 23.14 publish the list and any updates in the Minnesota health care programs provider manual;
- 23.15 (5) the initial applicable base year organization encounter rates for FQHCs and rural
- 23.16 health clinics shall be computed for services delivered on or after January 1, 2021, and:
- 23.17 (i) must be determined using each FQHC's and rural health clinic's Medicare cost reports
- 23.18 from 2017 and 2018;
- 23.19 (ii) must be according to current applicable Medicare cost principles as applicable to
- 23.20 FQHCs and rural health clinics without the application of productivity screens and upper
- 23.21 payment limits or the Medicare prospective payment system FQHC aggregate mean upper
- 23.22 payment limit;
- 23.23 (iii) must be subsequently rebased every two years thereafter using the Medicare cost
- 23.24 reports that are three and four years prior to the rebasing year. Years in which organizational
- 23.25 cost or claims volume is reduced or altered due to a pandemic, disease, or other public health
- 23.26 emergency shall not be used as part of a base year when the base year includes more than
- 23.27 one year. The commissioner may use the Medicare cost reports of a year unaffected by a
- 23.28 pandemic, disease, or other public health emergency, or previous two consecutive years,
- 23.29 inflated to the base year as established under item (iv);
- 23.30 (iv) must be inflated to the base year using the inflation factor described in clause (6);
- 23.31 and

24.1 (v) the commissioner must provide for a 60-day appeals process under section 14.57;

24.2 (6) the commissioner shall annually inflate the applicable organization encounter rates  
24.3 for FQHCs and rural health clinics from the base year payment rate to the effective date by  
24.4 using the CMS FQHC Market Basket inflator established under United States Code, title  
24.5 42, section 1395m(o), less productivity;

24.6 (7) FQHCs and rural health clinics that have elected the alternative payment methodology  
24.7 under this paragraph shall submit all necessary documentation required by the commissioner  
24.8 to compute the rebased organization encounter rates no later than six months following the  
24.9 date the applicable Medicare cost reports are due to the Centers for Medicare and Medicaid  
24.10 Services;

24.11 (8) the commissioner shall reimburse FQHCs and rural health clinics an additional  
24.12 amount relative to their medical and dental organization encounter rates that is attributable  
24.13 to the tax required to be paid according to section 295.52, if applicable;

24.14 (9) FQHCs and rural health clinics may submit change of scope requests to the  
24.15 commissioner if the change of scope would result in an increase or decrease of 2.5 percent  
24.16 or higher in the medical or dental organization encounter rate currently received by the  
24.17 FQHC or rural health clinic;

24.18 (10) for FQHCs and rural health clinics seeking a change in scope with the commissioner  
24.19 under clause (9) that requires the approval of the scope change by the federal Health  
24.20 Resources Services Administration:

24.21 (i) FQHCs and rural health clinics shall submit the change of scope request, including  
24.22 the start date of services, to the commissioner within seven business days of submission of  
24.23 the scope change to the federal Health Resources Services Administration;

24.24 (ii) the commissioner shall establish the effective date of the payment change as the  
24.25 federal Health Resources Services Administration date of approval of the FQHC's or rural  
24.26 health clinic's scope change request, or the effective start date of services, whichever is  
24.27 later; and

24.28 (iii) within 45 days of one year after the effective date established in item (ii), the  
24.29 commissioner shall conduct a retroactive review to determine if the actual costs established  
24.30 under clause (3) or encounters result in an increase or decrease of 2.5 percent or higher in  
24.31 the medical or dental organization encounter rate, and if this is the case, the commissioner  
24.32 shall revise the rate accordingly and shall adjust payments retrospectively to the effective  
24.33 date established in item (ii);

25.1 (11) for change of scope requests that do not require federal Health Resources Services  
25.2 Administration approval, the FQHC and rural health clinic shall submit the request to the  
25.3 commissioner before implementing the change, and the effective date of the change is the  
25.4 date the commissioner received the FQHC's or rural health clinic's request, or the effective  
25.5 start date of the service, whichever is later. The commissioner shall provide a response to  
25.6 the FQHC's or rural health clinic's request within 45 days of submission and provide a final  
25.7 approval within 120 days of submission. This timeline may be waived at the mutual  
25.8 agreement of the commissioner and the FQHC or rural health clinic if more information is  
25.9 needed to evaluate the request;

25.10 (12) the commissioner, when establishing organization encounter rates for new FQHCs  
25.11 and rural health clinics, shall consider the patient caseload of existing FQHCs and rural  
25.12 health clinics in a 60-mile radius for organizations established outside of the seven-county  
25.13 metropolitan area, and in a 30-mile radius for organizations in the seven-county metropolitan  
25.14 area. If this information is not available, the commissioner may use Medicare cost reports  
25.15 or audited financial statements to establish base rates;

25.16 (13) the commissioner shall establish a quality measures workgroup that includes  
25.17 representatives from the Minnesota Association of Community Health Centers, FQHCs,  
25.18 and rural health clinics, to evaluate clinical and nonclinical measures; and

25.19 (14) the commissioner shall not disallow or reduce costs that are related to an FQHC's  
25.20 or rural health clinic's participation in health care educational programs to the extent that  
25.21 the costs are not accounted for in the alternative payment methodology encounter rate  
25.22 established in this paragraph.

25.23 (m) Effective July 1, 2023, an enrolled Indian health service facility or a Tribal health  
25.24 center operating under a 638 contract or compact may elect to also enroll as a Tribal FQHC.  
25.25 Requirements that otherwise apply to an FQHC covered in this subdivision do not apply to  
25.26 a Tribal FQHC enrolled under this paragraph, except that any requirements necessary to  
25.27 comply with federal regulations do apply to a Tribal FQHC. The commissioner shall establish  
25.28 an alternative payment method for a Tribal FQHC enrolled under this paragraph that uses  
25.29 the same method and rates applicable to a Tribal facility or health center that does not enroll  
25.30 as a Tribal FQHC.

25.31 Sec. 19. Minnesota Statutes 2022, section 256B.0625, subdivision 31, is amended to read:

25.32 Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical  
25.33 supplies and equipment. Separate payment outside of the facility's payment rate shall be  
25.34 made for wheelchairs and wheelchair accessories for recipients who are residents of

26.1 intermediate care facilities for the developmentally disabled. Reimbursement for wheelchairs  
26.2 and wheelchair accessories for ICF/DD recipients shall be subject to the same conditions  
26.3 and limitations as coverage for recipients who do not reside in institutions. A wheelchair  
26.4 purchased outside of the facility's payment rate is the property of the recipient.

26.5 (b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies  
26.6 must enroll as a Medicare provider.

26.7 (c) When necessary to ensure access to durable medical equipment, prosthetics, orthotics,  
26.8 or medical supplies, the commissioner may exempt a vendor from the Medicare enrollment  
26.9 requirement if:

26.10 (1) the vendor supplies only one type of durable medical equipment, prosthetic, orthotic,  
26.11 or medical supply;

26.12 (2) the vendor serves ten or fewer medical assistance recipients per year;

26.13 (3) the commissioner finds that other vendors are not available to provide same or similar  
26.14 durable medical equipment, prosthetics, orthotics, or medical supplies; and

26.15 (4) the vendor complies with all screening requirements in this chapter and Code of  
26.16 Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from  
26.17 the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare  
26.18 and Medicaid Services approved national accreditation organization as complying with the  
26.19 Medicare program's supplier and quality standards and the vendor serves primarily pediatric  
26.20 patients.

26.21 (d) Durable medical equipment means a device or equipment that:

26.22 (1) can withstand repeated use;

26.23 (2) is generally not useful in the absence of an illness, injury, or disability; and

26.24 (3) is provided to correct or accommodate a physiological disorder or physical condition  
26.25 or is generally used primarily for a medical purpose.

26.26 (e) Electronic tablets may be considered durable medical equipment if the electronic  
26.27 tablet will be used as an augmentative and alternative communication system as defined  
26.28 under subdivision 31a, paragraph (a). To be covered by medical assistance, the device must  
26.29 be locked in order to prevent use not related to communication.

26.30 (f) Notwithstanding the requirement in paragraph (e) that an electronic tablet must be  
26.31 locked to prevent use not as an augmentative communication device, a recipient of waiver  
26.32 services may use an electronic tablet for a use not related to communication when the

27.1 recipient has been authorized under the waiver to receive one or more additional applications  
27.2 that can be loaded onto the electronic tablet, such that allowing the additional use prevents  
27.3 the purchase of a separate electronic tablet with waiver funds.

27.4 (g) An order or prescription for medical supplies, equipment, or appliances must meet  
27.5 the requirements in Code of Federal Regulations, title 42, part 440.70.

27.6 (h) Allergen-reducing products provided according to subdivision 67, paragraph (c) or  
27.7 (d), shall be considered durable medical equipment.

27.8 (i) Seizure detection devices are covered as durable medical equipment under this  
27.9 subdivision if:

27.10 (1) the seizure detection device is medically appropriate based on the recipient's medical  
27.11 condition or status; and

27.12 (2) the recipient's health care provider has identified that a seizure detection device  
27.13 would:

27.14 (i) likely assist in reducing bodily harm to or death of the recipient as a result of the  
27.15 recipient experiencing a seizure; or

27.16 (ii) provide data to the health care provider necessary to appropriately diagnose or treat  
27.17 a health condition of the recipient that causes the seizure activity.

27.18 (j) For purposes of paragraph (i), "seizure detection device" means a United States Food  
27.19 and Drug Administration-approved monitoring device and related service or subscription  
27.20 supporting the prescribed use of the device, including technology that provides ongoing  
27.21 patient monitoring and alert services that detect seizure activity and transmit notification  
27.22 of the seizure activity to a caregiver for appropriate medical response or collects data of the  
27.23 seizure activity of the recipient that can be used by a health care provider to diagnose or  
27.24 appropriately treat a health care condition that causes the seizure activity.

27.25 **EFFECTIVE DATE.** This section is effective January 1, 2024, or upon federal approval,  
27.26 whichever is later. The commissioner of human services shall notify the revisor of statutes  
27.27 when federal approval is obtained.

27.28 Sec. 20. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision  
27.29 to read:

27.30 **Subd. 68. Tobacco and nicotine cessation.** (a) Medical assistance covers tobacco and  
27.31 nicotine cessation services, drugs to treat tobacco and nicotine addiction or dependence,  
27.32 and drugs to help individuals discontinue use of tobacco and nicotine products. Medical

28.1 assistance must cover services and drugs as provided in this subdivision consistent with  
28.2 evidence-based or evidence-informed best practices.

28.3 (b) Medical assistance must cover in-person individual and group tobacco and nicotine  
28.4 cessation education and counseling services if provided by a health care practitioner whose  
28.5 scope of practice encompasses tobacco and nicotine cessation education and counseling.  
28.6 Service providers include but are not limited to the following:

28.7 (1) mental health practitioners under section 245.462, subdivision 17;

28.8 (2) mental health professionals under section 245.462, subdivision 18;

28.9 (3) mental health certified peer specialists under section 256B.0615;

28.10 (4) alcohol and drug counselors licensed under chapter 148F;

28.11 (5) recovery peers as defined in section 245F.02, subdivision 21;

28.12 (6) certified tobacco treatment specialists;

28.13 (7) community health workers;

28.14 (8) physicians;

28.15 (9) physician assistants;

28.16 (10) advanced practice registered nurses; or

28.17 (11) other licensed or nonlicensed professionals or paraprofessionals with training in  
28.18 providing tobacco and nicotine cessation education and counseling services.

28.19 (c) Medical assistance covers telephone cessation counseling services provided through  
28.20 a quitline. Notwithstanding section 256B.0625, subdivision 3b, quitline services may be  
28.21 provided through audio-only communications. The commissioner of human services may  
28.22 utilize volume purchasing for quitline services consistent with section 256B.04, subdivision  
28.23 14.

28.24 (d) Medical assistance must cover all prescription and over-the-counter pharmacotherapy  
28.25 drugs approved by the United States Food and Drug Administration for cessation of tobacco  
28.26 and nicotine use or treatment of tobacco and nicotine dependence, and that are subject to a  
28.27 Medicaid drug rebate agreement.

28.28 (e) Services covered under this subdivision may be provided by telemedicine.

28.29 (f) The commissioner must not:

29.1 (1) restrict or limit the type, duration, or frequency of tobacco and nicotine cessation  
29.2 services;

29.3 (2) prohibit the simultaneous use of multiple cessation services, including but not limited  
29.4 to simultaneous use of counseling and drugs;

29.5 (3) require counseling before receiving drugs or as a condition of receiving drugs;

29.6 (4) limit pharmacotherapy drug dosage amounts for a dosing regimen for treatment of  
29.7 a medically accepted indication as defined in United States Code, title 14, section  
29.8 1396r-8(K)(6); limit dosing frequency; or impose duration limits;

29.9 (5) prohibit simultaneous use of multiple drugs, including prescription and  
29.10 over-the-counter drugs;

29.11 (6) require or authorize step therapy; or

29.12 (7) require or utilize prior authorization or require a co-payment or deductible for any  
29.13 tobacco and nicotine cessation services and drugs covered under this subdivision.

29.14 Sec. 21. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision  
29.15 to read:

29.16 Subd. 68. **Recuperative care services.** (a) Medical assistance covers recuperative care  
29.17 services provided in a setting that meets the requirements in paragraph (b) for recipients  
29.18 who meet the eligibility requirements in paragraph (c). For purposes of this subdivision,  
29.19 "recuperative care" means a model of care that prevents hospitalization or that provides  
29.20 postacute medical care and support services for recipients experiencing homelessness who  
29.21 are too ill or frail to recover from a physical illness or injury while living in a shelter or are  
29.22 otherwise unhoused but who are not sick enough to be hospitalized, or remain hospitalized,  
29.23 or to need other levels of care.

29.24 (b) Recuperative care may be provided in any setting, including but not limited to  
29.25 homeless shelters, congregate care settings, single room occupancy settings, or supportive  
29.26 housing, so long as the provider of recuperative care or provider of housing is able to provide  
29.27 to the recipient within the designated setting, at a minimum:

29.28 (1) 24-hour access to a bed and bathroom;

29.29 (2) access to three meals a day;

29.30 (3) availability to environmental services;

29.31 (4) access to a telephone;

- 30.1 (5) a secure place to store belongings; and
- 30.2 (6) staff available within the setting to provide a wellness check as needed, but at a  
30.3 minimum, at least once every 24 hours.
- 30.4 (c) To be eligible for this covered service, a recipient must:
- 30.5 (1) be 21 years of age or older;
- 30.6 (2) be experiencing homelessness;
- 30.7 (3) be in need of short term acute medical care for a period of no more than 60 days;
- 30.8 (4) meet clinical criteria, as established by the commissioner, that indicates that the  
30.9 recipient is in need of recuperative care; and
- 30.10 (5) not have behavioral health needs that are greater than what can be managed by the  
30.11 provider within the setting.
- 30.12 (d) Payment for recuperative care shall consist of two components. The first component  
30.13 must be for the services provided to the member and is a bundled daily per diem payment  
30.14 of at least \$300 per day. The second component must be for the facility costs and must be  
30.15 paid using state funds equivalent to the amount paid as the medical assistance room and  
30.16 board rate and annual adjustments. The eligibility standards in chapter 256I shall not apply.  
30.17 The second component is only paid when the first component is paid to a provider. Providers  
30.18 may opt to only be reimbursed for the first component. A provider under this subdivision  
30.19 means a recuperative care provider and is defined by the standards established by the National  
30.20 Institute for Medical Respite Care. Services provided within the bundled payment may  
30.21 include but are not limited to:
- 30.22 (1) basic nursing care, including:
- 30.23 (i) monitoring a patient's physical health and pain level;
- 30.24 (ii) providing wound care;
- 30.25 (iii) medication support;
- 30.26 (iv) patient education;
- 30.27 (v) immunization review and update; and
- 30.28 (vi) establishing clinical goals for the recuperative care period and discharge plan;
- 30.29 (2) care coordination, including:
- 30.30 (i) initial assessment of medical, behavioral, and social needs;

- 31.1 (ii) development of a care plan;
- 31.2 (iii) support and referral assistance for legal services, housing, community social services,  
31.3 case management, health care benefits, health and other eligible benefits, and transportation  
31.4 needs and services; and
- 31.5 (iv) monitoring and follow-up to ensure that the care plan is effectively implemented to  
31.6 address the medical, behavioral, and social needs;
- 31.7 (3) basic behavioral needs, including counseling and peer support, that can be provided  
31.8 in this recuperative care setting; and
- 31.9 (4) services provided by a community health worker as defined under subdivision 49.
- 31.10 (e) Before a recipient is discharged from a recuperative care setting, the provider must  
31.11 ensure that the recipient's acute medical condition is stabilized or that the recipient is being  
31.12 discharged to a setting that is able to meet that recipient's needs.
- 31.13 (f) If a recipient is temporarily absent due to an admission at a residential behavioral  
31.14 health facility, inpatient hospital, or nursing facility for a period of time exceeding the limits  
31.15 described in paragraph (d), the agency may request in a format prescribed by the  
31.16 commissioner an absence day limit exception to continue payments until the recipient is  
31.17 discharged.
- 31.18 (g) The commissioner shall submit an initial report to the chairs and ranking minority  
31.19 members of the legislative committees having jurisdiction over health and human services  
31.20 by February 1, 2025, and a final report by February 1, 2027, on coverage of recuperative  
31.21 care services. The reports must include, but are not limited to:
- 31.22 (1) a list of the recuperative care services in Minnesota and the number of recipients;
- 31.23 (2) the estimated return on investment, including health care savings due to reduced  
31.24 hospitalizations;
- 31.25 (3) follow-up information, if available, on whether recipients' hospital visits decreased  
31.26 since recuperative care services were provided compared to before the services were  
31.27 provided; and
- 31.28 (4) any other information that can be used to determine the effectiveness of the program  
31.29 and its funding, including recommendations for improvements to the program.
- 31.30 **EFFECTIVE DATE.** This section is effective January 1, 2024.

32.1 Sec. 22. Minnesota Statutes 2022, section 256B.196, subdivision 2, is amended to read:

32.2 Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and subdivision  
32.3 3, the commissioner shall determine the fee-for-service outpatient hospital services upper  
32.4 payment limit for nonstate government hospitals. The commissioner shall then determine  
32.5 the amount of a supplemental payment to Hennepin County Medical Center and Regions  
32.6 Hospital for these services that would increase medical assistance spending in this category  
32.7 to the aggregate upper payment limit for all nonstate government hospitals in Minnesota.  
32.8 In making this determination, the commissioner shall allot the available increases between  
32.9 Hennepin County Medical Center and Regions Hospital based on the ratio of medical  
32.10 assistance fee-for-service outpatient hospital payments to the two facilities. The commissioner  
32.11 shall adjust this allotment as necessary based on federal approvals, the amount of  
32.12 intergovernmental transfers received from Hennepin and Ramsey Counties, and other factors,  
32.13 in order to maximize the additional total payments. The commissioner shall inform Hennepin  
32.14 County and Ramsey County of the periodic intergovernmental transfers necessary to match  
32.15 federal Medicaid payments available under this subdivision in order to make supplementary  
32.16 medical assistance payments to Hennepin County Medical Center and Regions Hospital  
32.17 equal to an amount that when combined with existing medical assistance payments to  
32.18 nonstate governmental hospitals would increase total payments to hospitals in this category  
32.19 for outpatient services to the aggregate upper payment limit for all hospitals in this category  
32.20 in Minnesota. Upon receipt of these periodic transfers, the commissioner shall make  
32.21 supplementary payments to Hennepin County Medical Center and Regions Hospital.

32.22 (b) For the purposes of this subdivision and subdivision 3, the commissioner shall  
32.23 determine an upper payment limit for physicians and other billing professionals affiliated  
32.24 with Hennepin County Medical Center and with Regions Hospital. The upper payment limit  
32.25 shall be based on the average commercial rate or be determined using another method  
32.26 acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall  
32.27 inform Hennepin County and Ramsey County of the periodic intergovernmental transfers  
32.28 necessary to match the federal Medicaid payments available under this subdivision in order  
32.29 to make supplementary payments to physicians and other billing professionals affiliated  
32.30 with Hennepin County Medical Center and to make supplementary payments to physicians  
32.31 and other billing professionals affiliated with Regions Hospital through HealthPartners  
32.32 Medical Group equal to the difference between the established medical assistance payment  
32.33 for physician and other billing professional services and the upper payment limit. Upon  
32.34 receipt of these periodic transfers, the commissioner shall make supplementary payments  
32.35 to physicians and other billing professionals affiliated with Hennepin County Medical Center

33.1 and shall make supplementary payments to physicians and other billing professionals  
33.2 affiliated with Regions Hospital through HealthPartners Medical Group.

33.3 (c) Beginning January 1, 2010, Ramsey County may make monthly voluntary  
33.4 intergovernmental transfers to the commissioner in amounts not to exceed \$6,000,000 per  
33.5 year. The commissioner shall increase the medical assistance capitation payments to any  
33.6 licensed health plan under contract with the medical assistance program that agrees to make  
33.7 enhanced payments to Regions Hospital. The increase shall be in an amount equal to the  
33.8 annual value of the monthly transfers plus federal financial participation, with each health  
33.9 plan receiving its pro rata share of the increase based on the pro rata share of medical  
33.10 assistance admissions to Regions Hospital by those plans. For the purposes of this paragraph,  
33.11 "the base amount" means the total annual value of increased medical assistance capitation  
33.12 payments, including the voluntary intergovernmental transfers, under this paragraph in  
33.13 calendar year 2017. For managed care contracts beginning on or after January 1, 2018, the  
33.14 commissioner shall reduce the total annual value of increased medical assistance capitation  
33.15 payments under this paragraph by an amount equal to ten percent of the base amount, and  
33.16 by an additional ten percent of the base amount for each subsequent contract year until  
33.17 December 31, 2025. Upon the request of the commissioner, health plans shall submit  
33.18 individual-level cost data for verification purposes. The commissioner may ratably reduce  
33.19 these payments on a pro rata basis in order to satisfy federal requirements for actuarial  
33.20 soundness. If payments are reduced, transfers shall be reduced accordingly. Any licensed  
33.21 health plan that receives increased medical assistance capitation payments under the  
33.22 intergovernmental transfer described in this paragraph shall increase its medical assistance  
33.23 payments to Regions Hospital by the same amount as the increased payments received in  
33.24 the capitation payment described in this paragraph. This paragraph expires January 1, 2026.

33.25 (d) For the purposes of this subdivision and subdivision 3, the commissioner shall  
33.26 determine an upper payment limit for ambulance services affiliated with Hennepin County  
33.27 Medical Center and the city of St. Paul, and ambulance services owned and operated by  
33.28 another governmental entity that chooses to participate by requesting the commissioner to  
33.29 determine an upper payment limit. The upper payment limit shall be based on the average  
33.30 commercial rate or be determined using another method acceptable to the Centers for  
33.31 Medicare and Medicaid Services. The commissioner shall inform Hennepin County, the  
33.32 city of St. Paul, and other participating governmental entities of the periodic  
33.33 intergovernmental transfers necessary to match the federal Medicaid payments available  
33.34 under this subdivision in order to make supplementary payments to Hennepin County  
33.35 Medical Center, the city of St. Paul, and other participating governmental entities equal to

34.1 the difference between the established medical assistance payment for ambulance services  
34.2 and the upper payment limit. Upon receipt of these periodic transfers, the commissioner  
34.3 shall make supplementary payments to Hennepin County Medical Center, the city of St.  
34.4 Paul, and other participating governmental entities. A tribal government that owns and  
34.5 operates an ambulance service is not eligible to participate under this subdivision.

34.6 (e) For the purposes of this subdivision and subdivision 3, the commissioner shall  
34.7 determine an upper payment limit for physicians, dentists, and other billing professionals  
34.8 affiliated with the University of Minnesota and University of Minnesota Physicians. The  
34.9 upper payment limit shall be based on the average commercial rate or be determined using  
34.10 another method acceptable to the Centers for Medicare and Medicaid Services. The  
34.11 commissioner shall inform the University of Minnesota Medical School and University of  
34.12 Minnesota School of Dentistry of the periodic intergovernmental transfers necessary to  
34.13 match the federal Medicaid payments available under this subdivision in order to make  
34.14 supplementary payments to physicians, dentists, and other billing professionals affiliated  
34.15 with the University of Minnesota and the University of Minnesota Physicians equal to the  
34.16 difference between the established medical assistance payment for physician, dentist, and  
34.17 other billing professional services and the upper payment limit. Upon receipt of these periodic  
34.18 transfers, the commissioner shall make supplementary payments to physicians, dentists,  
34.19 and other billing professionals affiliated with the University of Minnesota and the University  
34.20 of Minnesota Physicians.

34.21 (f) The commissioner shall inform the transferring governmental entities on an ongoing  
34.22 basis of the need for any changes needed in the intergovernmental transfers in order to  
34.23 continue the payments under paragraphs (a) to (e), at their maximum level, including  
34.24 increases in upper payment limits, changes in the federal Medicaid match, and other factors.

34.25 (g) The payments in paragraphs (a) to (e) shall be implemented independently of each  
34.26 other, subject to federal approval and to the receipt of transfers under subdivision 3.

34.27 (h) All of the data and funding transactions related to the payments in paragraphs (a) to  
34.28 (e) shall be between the commissioner and the governmental entities. The commissioner  
34.29 shall not make payments to governmental entities eligible to receive payments described  
34.30 in paragraphs (a) to (e) that fail to submit the data needed to compute the payments within  
34.31 24 months of the initial request from the commissioner.

34.32 (i) For purposes of this subdivision, billing professionals are limited to physicians, nurse  
34.33 practitioners, nurse midwives, clinical nurse specialists, physician assistants,

35.1 anesthesiologists, certified registered nurse anesthetists, dentists, dental hygienists, and  
35.2 dental therapists.

35.3 **EFFECTIVE DATE.** This section is effective July 1, 2023.

35.4 Sec. 23. Minnesota Statutes 2022, section 256B.69, subdivision 5a, is amended to read:

35.5 Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and  
35.6 section 256L.12 shall be entered into or renewed on a calendar year basis. The commissioner  
35.7 may issue separate contracts with requirements specific to services to medical assistance  
35.8 recipients age 65 and older.

35.9 (b) A prepaid health plan providing covered health services for eligible persons pursuant  
35.10 to chapters 256B and 256L is responsible for complying with the terms of its contract with  
35.11 the commissioner. Requirements applicable to managed care programs under chapters 256B  
35.12 and 256L established after the effective date of a contract with the commissioner take effect  
35.13 when the contract is next issued or renewed.

35.14 (c) The commissioner shall withhold five percent of managed care plan payments under  
35.15 this section and county-based purchasing plan payments under section 256B.692 for the  
35.16 prepaid medical assistance program pending completion of performance targets. Each  
35.17 performance target must be quantifiable, objective, measurable, and reasonably attainable,  
35.18 except in the case of a performance target based on a federal or state law or rule. Criteria  
35.19 for assessment of each performance target must be outlined in writing prior to the contract  
35.20 effective date. Clinical or utilization performance targets and their related criteria must  
35.21 consider evidence-based research and reasonable interventions when available or applicable  
35.22 to the populations served, and must be developed with input from external clinical experts  
35.23 and stakeholders, including managed care plans, county-based purchasing plans, and  
35.24 providers. The managed care or county-based purchasing plan must demonstrate, to the  
35.25 commissioner's satisfaction, that the data submitted regarding attainment of the performance  
35.26 target is accurate. The commissioner shall periodically change the administrative measures  
35.27 used as performance targets in order to improve plan performance across a broader range  
35.28 of administrative services. The performance targets must include measurement of plan  
35.29 efforts to contain spending on health care services and administrative activities. The  
35.30 commissioner may adopt plan-specific performance targets that take into account factors  
35.31 affecting only one plan, including characteristics of the plan's enrollee population. The  
35.32 withheld funds must be returned no sooner than July of the following year if performance  
35.33 targets in the contract are achieved. The commissioner may exclude special demonstration  
35.34 projects under subdivision 23.

36.1 (d) The commissioner shall require that managed care plans:

36.2 (1) use the assessment and authorization processes, forms, timelines, standards,  
36.3 documentation, and data reporting requirements, protocols, billing processes, and policies  
36.4 consistent with medical assistance fee-for-service or the Department of Human Services  
36.5 contract requirements for all personal care assistance services under section 256B.0659 and  
36.6 community first services and supports under section 256B.85; and

36.7 (2) by January 30 of each year that follows a rate increase for any aspect of services  
36.8 under section 256B.0659 or 256B.85, inform the commissioner and the chairs and ranking  
36.9 minority members of the legislative committees with jurisdiction over rates determined  
36.10 under section 256B.851 of the amount of the rate increase that is paid to each personal care  
36.11 assistance provider agency with which the plan has a contract.

36.12 ~~(e) Effective for services rendered on or after January 1, 2012, the commissioner shall~~  
36.13 ~~include as part of the performance targets described in paragraph (c) a reduction in the health~~  
36.14 ~~plan's emergency department utilization rate for medical assistance and MinnesotaCare~~  
36.15 ~~enrollees, as determined by the commissioner. For 2012, the reduction shall be based on~~  
36.16 ~~the health plan's utilization in 2009. To earn the return of the withhold each subsequent~~  
36.17 ~~year, the managed care plan or county-based purchasing plan must achieve a qualifying~~  
36.18 ~~reduction of no less than ten percent of the plan's emergency department utilization rate for~~  
36.19 ~~medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described~~  
36.20 ~~in subdivisions 23 and 28, compared to the previous measurement year until the final~~  
36.21 ~~performance target is reached. When measuring performance, the commissioner must~~  
36.22 ~~consider the difference in health risk in a managed care or county-based purchasing plan's~~  
36.23 ~~membership in the baseline year compared to the measurement year, and work with the~~  
36.24 ~~managed care or county-based purchasing plan to account for differences that they agree~~  
36.25 ~~are significant.~~

36.26 ~~The withheld funds must be returned no sooner than July 1 and no later than July 31 of~~  
36.27 ~~the following calendar year if the managed care plan or county-based purchasing plan~~  
36.28 ~~demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate~~  
36.29 ~~was achieved. The commissioner shall structure the withhold so that the commissioner~~  
36.30 ~~returns a portion of the withheld funds in amounts commensurate with achieved reductions~~  
36.31 ~~in utilization less than the targeted amount.~~

36.32 ~~The withhold described in this paragraph shall continue for each consecutive contract~~  
36.33 ~~period until the plan's emergency room utilization rate for state health care program enrollees~~  
36.34 ~~is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance~~

37.1 ~~and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the~~  
37.2 ~~health plans in meeting this performance target and shall accept payment withholds that~~  
37.3 ~~may be returned to the hospitals if the performance target is achieved.~~

37.4 ~~(f) Effective for services rendered on or after January 1, 2012, the commissioner shall~~  
37.5 ~~include as part of the performance targets described in paragraph (c) a reduction in the plan's~~  
37.6 ~~hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as~~  
37.7 ~~determined by the commissioner. To earn the return of the withhold each year, the managed~~  
37.8 ~~care plan or county-based purchasing plan must achieve a qualifying reduction of no less~~  
37.9 ~~than five percent of the plan's hospital admission rate for medical assistance and~~  
37.10 ~~MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and~~  
37.11 ~~28, compared to the previous calendar year until the final performance target is reached.~~  
37.12 ~~When measuring performance, the commissioner must consider the difference in health risk~~  
37.13 ~~in a managed care or county-based purchasing plan's membership in the baseline year~~  
37.14 ~~compared to the measurement year, and work with the managed care or county-based~~  
37.15 ~~purchasing plan to account for differences that they agree are significant.~~

37.16 ~~The withheld funds must be returned no sooner than July 1 and no later than July 31 of~~  
37.17 ~~the following calendar year if the managed care plan or county-based purchasing plan~~  
37.18 ~~demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization~~  
37.19 ~~rate was achieved. The commissioner shall structure the withhold so that the commissioner~~  
37.20 ~~returns a portion of the withheld funds in amounts commensurate with achieved reductions~~  
37.21 ~~in utilization less than the targeted amount.~~

37.22 ~~The withhold described in this paragraph shall continue until there is a 25 percent~~  
37.23 ~~reduction in the hospital admission rate compared to the hospital admission rates in calendar~~  
37.24 ~~year 2011, as determined by the commissioner. The hospital admissions in this performance~~  
37.25 ~~target do not include the admissions applicable to the subsequent hospital admission~~  
37.26 ~~performance target under paragraph (g). Hospitals shall cooperate with the plans in meeting~~  
37.27 ~~this performance target and shall accept payment withholds that may be returned to the~~  
37.28 ~~hospitals if the performance target is achieved.~~

37.29 ~~(g) Effective for services rendered on or after January 1, 2012, the commissioner shall~~  
37.30 ~~include as part of the performance targets described in paragraph (c) a reduction in the plan's~~  
37.31 ~~hospitalization admission rates for subsequent hospitalizations within 30 days of a previous~~  
37.32 ~~hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare~~  
37.33 ~~enrollees, as determined by the commissioner. To earn the return of the withhold each year,~~  
37.34 ~~the managed care plan or county-based purchasing plan must achieve a qualifying reduction~~  
37.35 ~~of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees,~~

38.1 ~~excluding enrollees in programs described in subdivisions 23 and 28, of no less than five~~  
38.2 ~~percent compared to the previous calendar year until the final performance target is reached.~~

38.3 ~~The withheld funds must be returned no sooner than July 1 and no later than July 31 of~~  
38.4 ~~the following calendar year if the managed care plan or county-based purchasing plan~~  
38.5 ~~demonstrates to the satisfaction of the commissioner that a qualifying reduction in the~~  
38.6 ~~subsequent hospitalization rate was achieved. The commissioner shall structure the withhold~~  
38.7 ~~so that the commissioner returns a portion of the withheld funds in amounts commensurate~~  
38.8 ~~with achieved reductions in utilization less than the targeted amount.~~

38.9 ~~The withhold described in this paragraph must continue for each consecutive contract~~  
38.10 ~~period until the plan's subsequent hospitalization rate for medical assistance and~~  
38.11 ~~MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and~~  
38.12 ~~28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year~~  
38.13 ~~2011. Hospitals shall cooperate with the plans in meeting this performance target and shall~~  
38.14 ~~accept payment withholds that must be returned to the hospitals if the performance target~~  
38.15 ~~is achieved.~~

38.16 ~~(h)~~ (e) Effective for services rendered on or after January 1, 2013, through December  
38.17 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under  
38.18 this section and county-based purchasing plan payments under section 256B.692 for the  
38.19 prepaid medical assistance program. The withheld funds must be returned no sooner than  
38.20 July 1 and no later than July 31 of the following year. The commissioner may exclude  
38.21 special demonstration projects under subdivision 23.

38.22 ~~(i)~~ (f) Effective for services rendered on or after January 1, 2014, the commissioner shall  
38.23 withhold three percent of managed care plan payments under this section and county-based  
38.24 purchasing plan payments under section 256B.692 for the prepaid medical assistance  
38.25 program. The withheld funds must be returned no sooner than July 1 and no later than July  
38.26 31 of the following year. The commissioner may exclude special demonstration projects  
38.27 under subdivision 23.

38.28 ~~(j)~~ (g) A managed care plan or a county-based purchasing plan under section 256B.692  
38.29 may include as admitted assets under section 62D.044 any amount withheld under this  
38.30 section that is reasonably expected to be returned.

38.31 ~~(k)~~ (h) Contracts between the commissioner and a prepaid health plan are exempt from  
38.32 the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a),  
38.33 and 7.

39.1 ~~(h)~~ (i) The return of the withhold under paragraphs (h) and (i) is not subject to the  
39.2 requirements of paragraph (c).

39.3 ~~(m)~~ (j) Managed care plans and county-based purchasing plans shall maintain current  
39.4 and fully executed agreements for all subcontractors, including bargaining groups, for  
39.5 administrative services that are expensed to the state's public health care programs.  
39.6 Subcontractor agreements determined to be material, as defined by the commissioner after  
39.7 taking into account state contracting and relevant statutory requirements, must be in the  
39.8 form of a written instrument or electronic document containing the elements of offer,  
39.9 acceptance, consideration, payment terms, scope, duration of the contract, and how the  
39.10 subcontractor services relate to state public health care programs. Upon request, the  
39.11 commissioner shall have access to all subcontractor documentation under this paragraph.  
39.12 Nothing in this paragraph shall allow release of information that is nonpublic data pursuant  
39.13 to section 13.02.

39.14 **EFFECTIVE DATE.** This section is effective January 1, 2024.

39.15 Sec. 24. Minnesota Statutes 2022, section 256B.76, subdivision 1, is amended to read:

39.16 Subdivision 1. **Physician reimbursement.** (a) Effective for services rendered on or after  
39.17 October 1, 1992, the commissioner shall make payments for physician services as follows:

39.18 (1) payment for level one Centers for Medicare and Medicaid Services' common  
39.19 procedural coding system codes titled "office and other outpatient services," "preventive  
39.20 medicine new and established patient," "delivery, antepartum, and postpartum care," "critical  
39.21 care," cesarean delivery and pharmacologic management provided to psychiatric patients,  
39.22 and level three codes for enhanced services for prenatal high risk, shall be paid at the lower  
39.23 of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992;

39.24 (2) payments for all other services shall be paid at the lower of (i) submitted charges,  
39.25 or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

39.26 (3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th  
39.27 percentile of 1989, less the percent in aggregate necessary to equal the above increases  
39.28 except that payment rates for home health agency services shall be the rates in effect on  
39.29 September 30, 1992.

39.30 (b) Effective for services rendered on or after January 1, 2000, payment rates for physician  
39.31 and professional services shall be increased by three percent over the rates in effect on  
39.32 December 31, 1999, except for home health agency and family planning agency services.  
39.33 The increases in this paragraph shall be implemented January 1, 2000, for managed care.

40.1 (c) Effective for services rendered on or after July 1, 2009, payment rates for physician  
40.2 and professional services shall be reduced by five percent, except that for the period July  
40.3 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent for the medical  
40.4 assistance and general assistance medical care programs, over the rates in effect on June  
40.5 30, 2009. This reduction and the reductions in paragraph (d) do not apply to office or other  
40.6 outpatient visits, preventive medicine visits and family planning visits billed by physicians,  
40.7 advanced practice nurses, or physician assistants in a family planning agency or in one of  
40.8 the following primary care practices: general practice, general internal medicine, general  
40.9 pediatrics, general geriatrics, and family medicine. This reduction and the reductions in  
40.10 paragraph (d) do not apply to federally qualified health centers, rural health centers, and  
40.11 Indian health services. Effective October 1, 2009, payments made to managed care plans  
40.12 and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall  
40.13 reflect the payment reduction described in this paragraph.

40.14 (d) Effective for services rendered on or after July 1, 2010, payment rates for physician  
40.15 and professional services shall be reduced an additional seven percent over the five percent  
40.16 reduction in rates described in paragraph (c). This additional reduction does not apply to  
40.17 physical therapy services, occupational therapy services, and speech pathology and related  
40.18 services provided on or after July 1, 2010. This additional reduction does not apply to  
40.19 physician services billed by a psychiatrist or an advanced practice nurse with a specialty in  
40.20 mental health. Effective October 1, 2010, payments made to managed care plans and  
40.21 county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect  
40.22 the payment reduction described in this paragraph.

40.23 (e) Effective for services rendered on or after September 1, 2011, through June 30, 2013,  
40.24 payment rates for physician and professional services shall be reduced three percent from  
40.25 the rates in effect on August 31, 2011. This reduction does not apply to physical therapy  
40.26 services, occupational therapy services, and speech pathology and related services.

40.27 (f) Effective for services rendered on or after September 1, 2014, payment rates for  
40.28 physician and professional services, including physical therapy, occupational therapy, speech  
40.29 pathology, and mental health services shall be increased by five percent from the rates in  
40.30 effect on August 31, 2014. In calculating this rate increase, the commissioner shall not  
40.31 include in the base rate for August 31, 2014, the rate increase provided under section  
40.32 256B.76, subdivision 7. This increase does not apply to federally qualified health centers,  
40.33 rural health centers, and Indian health services. Payments made to managed care plans and  
40.34 county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

41.1 (g) Effective for services rendered on or after July 1, 2015, payment rates for physical  
41.2 therapy, occupational therapy, and speech pathology and related services provided by a  
41.3 hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause  
41.4 (4), shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments  
41.5 made to managed care plans and county-based purchasing plans shall not be adjusted to  
41.6 reflect payments under this paragraph.

41.7 (h) Any rates effective before July 1, 2015, do not apply to early intensive  
41.8 developmental and behavioral intervention (EIDBI) benefits described in section 256B.0949.

41.9 (i) The commissioner may reimburse the cost incurred to pay the Department of Health  
41.10 for metabolic disorder testing of newborns who are medical assistance recipients when the  
41.11 sample is collected outside of an inpatient hospital setting or freestanding birth center setting  
41.12 because the newborn was born outside of a hospital setting or freestanding birth center  
41.13 setting or because it is not medically appropriate to collect the sample during the inpatient  
41.14 stay for the birth.

41.15 Sec. 25. Minnesota Statutes 2022, section 256B.764, is amended to read:

41.16 **256B.764 REIMBURSEMENT FOR FAMILY PLANNING SERVICES.**

41.17 (a) Effective for services rendered on or after July 1, 2007, payment rates for family  
41.18 planning services shall be increased by 25 percent over the rates in effect June 30, 2007,  
41.19 when these services are provided by a community clinic as defined in section 145.9268,  
41.20 subdivision 1.

41.21 (b) Effective for services rendered on or after July 1, 2013, payment rates for family  
41.22 planning services shall be increased by 20 percent over the rates in effect June 30, 2013,  
41.23 when these services are provided by a community clinic as defined in section 145.9268,  
41.24 subdivision 1. The commissioner shall adjust capitation rates to managed care and  
41.25 county-based purchasing plans to reflect this increase, and shall require plans to pass on the  
41.26 full amount of the rate increase to eligible community clinics, in the form of higher payment  
41.27 rates for family planning services.

41.28 (c) Effective for services provided on or after January 1, 2024, payment rates for family  
41.29 planning and abortion services shall be increased by ten percent. This increase does not  
41.30 apply to federally qualified health centers, rural health centers, or Indian health services.

42.1 Sec. 26. Minnesota Statutes 2022, section 256L.03, subdivision 1, is amended to read:

42.2 Subdivision 1. **Covered health services.** (a) "Covered health services" means the health  
42.3 services reimbursed under chapter 256B, with the exception of special education services,  
42.4 home care nursing services, adult dental care services other than services covered under  
42.5 section 256B.0625, subdivision 9, orthodontic services, nonemergency medical transportation  
42.6 services, personal care assistance and case management services, community first services  
42.7 and supports under section 256B.85, behavioral health home services under section  
42.8 256B.0757, housing stabilization services under section 256B.051, and nursing home or  
42.9 intermediate care facilities services.

42.10 ~~(b) No public funds shall be used for coverage of abortion under MinnesotaCare except~~  
42.11 ~~where the life of the female would be endangered or substantial and irreversible impairment~~  
42.12 ~~of a major bodily function would result if the fetus were carried to term; or where the~~  
42.13 ~~pregnancy is the result of rape or incest.~~

42.14 ~~(e)~~ (b) Covered health services shall be expanded as provided in this section.

42.15 ~~(d)~~ (c) For the purposes of covered health services under this section, "child" means an  
42.16 individual younger than 19 years of age.

42.17 **EFFECTIVE DATE.** This section is effective the day following final enactment.

42.18 Sec. 27. Minnesota Statutes 2022, section 256L.03, subdivision 5, is amended to read:

42.19 Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to  
42.20 children under the age of 21 and to American Indians as defined in Code of Federal  
42.21 Regulations, title 42, section 600.5.

42.22 (b) The commissioner ~~shall~~ must adjust co-payments, coinsurance, and deductibles for  
42.23 covered services in a manner sufficient to maintain the actuarial value of the benefit to 94  
42.24 percent. The cost-sharing changes described in this paragraph do not apply to eligible  
42.25 recipients or services exempt from cost-sharing under state law. The cost-sharing changes  
42.26 described in this paragraph shall not be implemented prior to January 1, 2016.

42.27 (c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements  
42.28 for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations,  
42.29 title 42, sections 600.510 and 600.520.

42.30 (d) Cost-sharing must not apply to drugs used for tobacco and nicotine cessation or to  
42.31 tobacco and nicotine cessation services covered under section 256B.0625, subdivision 68.

43.1 Sec. 28. Laws 2021, First Special Session chapter 7, article 6, section 26, is amended to  
43.2 read:

43.3 Sec. 26. **COMMISSIONER OF HUMAN SERVICES; EXTENSION OF COVID-19**  
43.4 **HUMAN SERVICES PROGRAM MODIFICATIONS.**

43.5 Notwithstanding Laws 2020, First Special Session chapter 7, section 1, subdivision 2,  
43.6 as amended by Laws 2020, Third Special Session chapter 1, section 3, when the peacetime  
43.7 emergency declared by the governor in response to the COVID-19 outbreak expires, is  
43.8 terminated, or is rescinded by the proper authority, the following modifications issued by  
43.9 the commissioner of human services pursuant to Executive Orders 20-11 and 20-12, and  
43.10 including any amendments to the modification issued before the peacetime emergency  
43.11 expires, shall remain in effect until July 1, ~~2023~~ 2025:

43.12 (1) CV16: expanding access to telemedicine services for Children's Health Insurance  
43.13 Program, Medical Assistance, and MinnesotaCare enrollees; and

43.14 (2) CV21: allowing telemedicine alternative for school-linked mental health services  
43.15 and intermediate school district mental health services.

43.16 Sec. 29. **DENTAL HOME PILOT PROJECT.**

43.17 Subdivision 1. Establishment; requirements. (a) The commissioner of human services  
43.18 shall establish a dental home pilot project to increase access of medical assistance and  
43.19 MinnesotaCare enrollees to dental care, improve patient experience, and improve oral health  
43.20 clinical outcomes, in a manner that sustains the financial viability of the dental workforce  
43.21 and broader dental care delivery and financing system. Dental homes must provide  
43.22 high-quality, patient-centered, comprehensive, and coordinated oral health services across  
43.23 clinical and community-based settings, including virtual oral health care.

43.24 (b) The design and operation of the dental home pilot project must be consistent with  
43.25 the recommendations made by the Dental Services Advisory Committee to the legislature  
43.26 under Laws 2021, First Special Session chapter 7, article 1, section 33.

43.27 (c) The commissioner shall establish baseline requirements and performance measures  
43.28 for dental homes participating in the pilot project. These baseline requirements and  
43.29 performance measures must address access and patient experience and oral health clinical  
43.30 outcomes.

44.1 Subd. 2. Project design and timeline. (a) The commissioner shall issue a preliminary  
44.2 project description and a request for information to obtain stakeholder feedback and input  
44.3 on project design issues, including but not limited to:

44.4 (1) the timeline for project implementation;

44.5 (2) the length of each project phase and the date for full project implementation;

44.6 (3) the number of providers to be selected for participation;

44.7 (4) grant amounts;

44.8 (5) criteria and procedures for any value-based payments;

44.9 (6) the extent to which pilot project requirements may vary with provider characteristics;

44.10 (7) procedures for data collection;

44.11 (8) the role of dental partners, such as dental professional organizations and educational  
44.12 institutions;

44.13 (9) provider support and education; and

44.14 (10) other topics identified by the commissioner.

44.15 (b) The commissioner shall consider the feedback and input obtained in paragraph (a)  
44.16 and shall develop and issue a request for proposals for participation in the pilot project.

44.17 (c) The pilot project must be implemented by July 1, 2024, and must include initial pilot  
44.18 testing and the collection and analysis of data on baseline requirements and performance  
44.19 measures to evaluate whether these requirements and measures are appropriate. Under this  
44.20 phase, the commissioner shall provide grants to individual providers and provider networks  
44.21 in addition to medical assistance and MinnesotaCare payments received for services provided.

44.22 (d) The pilot project may test and analyze value-based payments to providers to determine  
44.23 whether varying payments based on dental home performance measures is appropriate and  
44.24 effective.

44.25 (e) The commissioner shall ensure provider diversity in selecting project participants.  
44.26 In selecting providers, the commissioner shall consider: geographic distribution; provider  
44.27 size, type, and location; providers serving different priority populations; health equity issues;  
44.28 and provider accessibility for patients with varying levels and types of disability.

44.29 (f) In designing and implementing the pilot project, the commissioner shall regularly  
44.30 consult with project participants and other stakeholders, and as relevant shall continue to  
44.31 seek the input of participants and other stakeholders on the topics listed in paragraph (a).

45.1 Subd. 3. **Reporting.** (a) The commissioner, beginning February 15, 2024, and each  
45.2 February 15 thereafter for the duration of the demonstration project, shall report on the  
45.3 design, implementation, operation, and results of the demonstration project to the chairs  
45.4 and ranking minority members of the legislative committees with jurisdiction over health  
45.5 care finance and policy.

45.6 (b) The commissioner, within six months from the date the pilot project ceases operation,  
45.7 shall report to the chairs and ranking minority members of the legislative committees with  
45.8 jurisdiction over health care finance and policy on the results of the demonstration project,  
45.9 and shall include in the report recommendations on whether the demonstration project, or  
45.10 specific features of the demonstration project, should be extended to all dental providers  
45.11 serving medical assistance and MinnesotaCare enrollees.

45.12 **Sec. 30. REPEALER.**

45.13 Minnesota Rules, part 9505.0235, is repealed the day following final enactment.

## 45.14 **ARTICLE 2**

### 45.15 **HEALTH CARE AFFORDABILITY AND DELIVERY**

45.16 **Section 1. [62J.0411] HEALTH CARE AFFORDABILITY COMMISSION.**

45.17 Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have  
45.18 the meanings given.

45.19 (b) "Commission" means the Health Care Affordability Commission.

45.20 (c) "Commissioner" means the commissioner of health.

45.21 (d) "Health care entity" includes, but is not limited to, clinics, hospitals, ambulatory  
45.22 surgical centers, physician organizations, accountable care organizations, integrated provider  
45.23 and plan systems, county-based purchasing plans, and health plan companies.

45.24 (e) "Health care provider" or "provider" means a health care professional who is licensed  
45.25 or registered by the state to perform health care services within the provider's scope of  
45.26 practice and in accordance with state law.

45.27 (f) "Health plan" means a health plan as defined in section 62A.011, subdivision 3.

45.28 (g) "Health plan company" means a health carrier as defined under section 62A.011,  
45.29 subdivision 2.

45.30 (h) "Hospital" means an entity licensed under sections 144.50 to 144.58.

46.1 Subd. 2. **Commission membership.** (a) The commissioner of health shall establish a  
46.2 health care affordability commission that shall consist of the following 15 members:

46.3 (1) two members with expertise and experience in advocating on behalf of patients;

46.4 (2) two Minnesota residents who are health care consumers, one residing in greater  
46.5 Minnesota and one residing in a metropolitan area, one of whom represents an underserved  
46.6 community;

46.7 (3) one member representing Indian Tribes;

46.8 (4) two members of the business community who purchase health insurance for their  
46.9 employees, one of whom purchases coverage in the small group market;

46.10 (5) two members representing public purchasers of health insurance for their employees;

46.11 (6) one licensed and certified health care provider employed at a federally qualified  
46.12 health center;

46.13 (7) one member representing a health care system or urban hospitals;

46.14 (8) one member representing rural hospitals;

46.15 (9) one member representing health plans;

46.16 (10) one member who is an expert in health care financing and administration; and

46.17 (11) one member who is an expert in health economics.

46.18 (b) All members appointed must have the knowledge and demonstrated expertise in one  
46.19 of the following areas of expertise, and each area of expertise must be met by at least one  
46.20 member of the commission:

46.21 (1) health care finance, health economics, and health care management or administration  
46.22 at a senior level;

46.23 (2) health care consumer advocacy;

46.24 (3) representing the health care workforce as a leader in a labor organization;

46.25 (4) purchasing health insurance representing business management or health benefits  
46.26 administration;

46.27 (5) delivering primary care, health plan administration, or public or population health;

46.28 or

46.29 (6) addressing health disparities and structural inequities.

47.1 (c) No member may participate in commission proceedings involving an individual  
47.2 provider, purchaser, or patient, or specific activity or transaction, if the member has direct  
47.3 financial interest in the outcome of the commission's proceedings other than as an individual  
47.4 consumer of health care services.

47.5 Subd. 3. **Terms.** (a) The commissioners of health, human services, and commerce shall  
47.6 make recommendations for commission membership. Commission members shall be  
47.7 appointed by the governor. The initial appointments to the commission shall be made by  
47.8 September 1, 2023. The initial appointed commission members shall serve staggered terms  
47.9 of three or four years determined by lot by the secretary of state. Following the initial  
47.10 appointments, the commission members shall serve four-year terms. Members may not  
47.11 serve more than two consecutive terms.

47.12 (b) The commission is governed by section 15.0575, except as otherwise provided in  
47.13 this section.

47.14 (c) A commission member may resign at any time by giving written notice to the  
47.15 commission.

47.16 Subd. 4. **Chair; other officers.** (a) The governor shall annually designate a member to  
47.17 serve as chair of the commission. The chair shall serve for one year. If there is a vacancy  
47.18 for any cause, the governor shall make an appointment for that category of membership and  
47.19 expertise, to become immediately effective.

47.20 (b) The commission shall elect a vice-chair and other officers from its membership as  
47.21 it deems necessary.

47.22 Subd. 5. **Compensation.** Commission members may be compensated according to  
47.23 section 15.0575.

47.24 Subd. 6. **Meetings.** (a) Meetings of the commission, including any public hearings, are  
47.25 subject to chapter 13D.

47.26 (b) The commission must meet publicly on at least a monthly basis until the initial growth  
47.27 targets are established.

47.28 (c) After the initial growth targets are established, the commission shall meet at least  
47.29 quarterly at which it considers summary data presented by the commissioner and drafts  
47.30 main findings for their reporting, considers updates to the program and growth target levels,  
47.31 discusses findings with health care providers and payers, and identifies additional needed  
47.32 analysis and strategies to limit health care spending growth.

48.1 Subd. 7. **Hearings.** At least annually, the commission shall hold public hearings to  
48.2 present findings from spending growth target monitoring. The commission shall also regularly  
48.3 hold public hearings to take testimony from stakeholders on health care spending growth,  
48.4 setting and revising health care spending growth targets, the impact of spending growth and  
48.5 growth targets on health care access and quality, and as needed to perform assigned duties.

48.6 Subd. 8. **Staff; technical assistance; contracting.** (a) The commission shall hire a  
48.7 full-time executive director and administrative staff, who shall serve in the unclassified  
48.8 service. The executive director must have significant knowledge and expertise in health  
48.9 economics and demonstrated experience in health policy.

48.10 (b) The attorney general shall provide legal services to the commission.

48.11 (c) The commissioner of health shall provide technical assistance to the commission  
48.12 related to data collection, analyzing health care trends and costs, and setting health care  
48.13 spending growth targets.

48.14 (d) The commission may employ or contract for professional and technical assistance,  
48.15 including actuarial assistance, as the commission deems necessary to perform the  
48.16 commission's duties.

48.17 Subd. 9. **Administration.** The commissioner of health shall provide office space,  
48.18 equipment and supplies, and analytic staff support to the commission and the Health Care  
48.19 Affordability Advisory Council.

48.20 Subd. 10. **Duties of the commissioner.** (a) The commissioner, in consultation with the  
48.21 commissioners of commerce and human services, shall provide staff support to the  
48.22 commission, including performing and procuring consulting and analytic services. The  
48.23 commissioner shall:

48.24 (1) establish the form and manner of data reporting, including reporting methods and  
48.25 dates, consistent with program design and timelines formalized by the commission;

48.26 (2) under the authority in chapter 62J, collect data identified by the commission for use  
48.27 in the program in a form and manner that ensures the collection of high-quality, transparent  
48.28 data;

48.29 (3) provide analytical support, including by conducting background research or  
48.30 environmental scans, evaluating the suitability of available data, performing needed analysis  
48.31 and data modeling, calculating performance under the spending trends, and researching  
48.32 drivers of spending growth trends;

49.1 (4) assist health care entities subject to the targets with reporting of data, internal analysis  
49.2 of spending growth trends, and, as necessary, methodological issues;

49.3 (5) synthesize information and report to the commission; and

49.4 (6) make appointments and staff the Health Care Affordability Advisory Council under  
49.5 section 62J.0414.

49.6 (b) In carrying out the duties required by this section, the commissioner may contract  
49.7 with entities with expertise in health economic, health finance, and actuarial science.

49.8 Subd. 11. **Access to information.** (a) The commission or commissioner may request  
49.9 that a state agency provide the commission with data as defined in sections 62J.04 and  
49.10 295.52 in a usable format as requested by the commission, at no cost to the commission.

49.11 (b) The commission may request from a state agency unique or custom data sets, and  
49.12 the agency may charge the commission for providing the data at the same rate the agency  
49.13 would charge any other public or private entity. The commission may grant the commissioner  
49.14 access to this data.

49.15 (c) Any information provided to the commission or commissioner by a state agency  
49.16 must be de-identified. For purposes of this subdivision, "de-identified" means the process  
49.17 used to prevent the identity of a person from being connected with information and ensuring  
49.18 all identifiable information has been removed.

49.19 (d) Any data submitted to the commission or the commissioner shall retain their original  
49.20 classification under the Minnesota Data Practices Act in chapter 13.

49.21 (e) The commissioner, under the authority of chapter 62J, may collect data necessary  
49.22 for the performance of its duties, and shall collect this data in a form and manner that ensures  
49.23 the collection of high-quality, transparent data.

49.24 **Sec. 2. [62J.0412] DUTIES OF THE COMMISSION; GENERAL.**

49.25 Subdivision 1. **Health care delivery and payment.** (a) The commission shall monitor  
49.26 the administration and reform of the health care delivery and payment systems in the state.  
49.27 The commission shall:

49.28 (1) set health care spending growth targets for the state;

49.29 (2) enhance the transparency of provider organizations;

49.30 (3) monitor the adoption and effectiveness of alternative payment methodologies;

50.1 (4) foster innovative health care delivery and payment models that lower health care  
50.2 cost growth while improving the quality of patient care;

50.3 (5) monitor and review the impact of changes within the health care marketplace; and

50.4 (6) monitor patient access to necessary health care services.

50.5 (b) The commission shall establish goals to reduce health care disparities in racial and  
50.6 ethnic communities and to ensure access to quality care for persons with disabilities or with  
50.7 chronic or complex health conditions.

50.8 Subd. 2. **Duties of the commission; market trends.** The commission shall monitor  
50.9 efforts to reform the health care delivery and payment system in Minnesota to understand  
50.10 emerging trends in the commercial health insurance market, including large self-insured  
50.11 employers and the state's public health care programs, in order to identify opportunities for  
50.12 state action to achieve:

50.13 (1) improved patient experience of care, including quality and satisfaction;

50.14 (2) improved health of all populations, including a reduction in health disparities; and

50.15 (3) a reduction in the growth of health care costs.

50.16 Subd. 3. **Duties of the commission; recommendations for reform.** The commission  
50.17 shall make recommendations for legislative policy, market, or any other reforms to:

50.18 (1) lower the rate of growth in commercial health care costs and public health care  
50.19 program spending in the state;

50.20 (2) positively impact the state's rankings in the areas listed in this subdivision and  
50.21 subdivision 2; and

50.22 (3) improve the quality and value of care for all Minnesotans, and for specific populations  
50.23 adversely affected by health disparities.

50.24 Sec. 3. **[62J.0413] DUTIES OF THE COMMISSION; GROWTH TARGETS.**

50.25 Subdivision 1. **Growth target program.** The commission is responsible for the  
50.26 development, establishment, and operation of the health care spending growth target program,  
50.27 determining the health care entities subject to health care spending growth targets, and  
50.28 reporting on progress toward targets to the legislature and the public.

50.29 Subd. 2. **Methodologies for growth targets.** (a) The commission shall develop a  
50.30 methodology to establish the health care spending growth targets and identify the economic

- 51.1 indicators to be used in establishing the initial and subsequent growth targets. Growth targets  
51.2 must:
- 51.3 (1) use a clear and operational definition of total health care spending for the state;  
51.4 (2) promote a predictable and sustainable rate of growth for total health care spending  
51.5 as measured by an established economic indicator, such as the rate of increase of the state's  
51.6 economy or of the personal income of residents of the state, or a combination;  
51.7 (3) apply to all health care entities, as defined by the commission;  
51.8 (4) be measurable on a per capita basis, statewide basis, health plan company basis,  
51.9 health plan basis, and health care provider basis;  
51.10 (5) account for the health status of patients; and  
51.11 (6) incorporate specific benchmarks related to health equity.
- 51.12 (b) The commission shall establish a methodology for calculating health care cost growth  
51.13 statewide, and for each health care provider and health plan company. In developing this  
51.14 methodology, the commissioner shall:
- 51.15 (1) at the discretion of the commission, account for variability by age and sex;  
51.16 (2) take into consideration the need for variability in targets across public and private  
51.17 payers;  
51.18 (3) incorporate health equity considerations; and  
51.19 (4) consider the impact of targets on health care access and health care disparities.
- 51.20 (c) The commission, when developing this methodology, shall determine which health  
51.21 care entities are subject to targets, and at what level of aggregation.
- 51.22 Subd. 3. **Data on performance.** The commission shall identify the data to be used for  
51.23 tracking performance toward achieving health care spending growth targets, and adopt  
51.24 methods of data collection. In identifying data and methods, the commission shall:
- 51.25 (1) consider the availability, timeliness, quality, and usefulness of existing data;  
51.26 (2) assess the need for additional investments in data collection, data validation, or  
51.27 analysis capacity to support efficient collection and aggregation of data to support the  
51.28 commission's activities;  
51.29 (3) limit the reporting burden to the greatest extent possible; and

52.1 (4) identify and define the health care entities that are required to report to the  
52.2 commissioner.

52.3 Subd. 4. **Reporting requirements.** The commission shall establish requirements for  
52.4 health care providers and health plan companies to report data and other information  
52.5 necessary to calculate health care cost growth. Health care providers and health plans must  
52.6 report data in the form and manner established by the commission.

52.7 Subd. 5. **Establishment of growth targets.** (a) The commission, by June 15, 2024, shall  
52.8 establish annual health care spending growth targets consistent with the methodology in  
52.9 subdivision 2 for each of the next five calendar years, with the goal of limiting health care  
52.10 spending growth. The commission may continue to establish annual health care spending  
52.11 growth targets for subsequent years.

52.12 (b) The commission shall regularly review all components of the program methodology,  
52.13 including economic indicators and other factors, and, as appropriate, revise established  
52.14 health care spending growth target levels. Any changes to health care spending growth  
52.15 target levels require a two-thirds majority vote of the commission.

52.16 Subd. 6. **Additional criteria for growth targets.** (a) In developing the health care  
52.17 spending growth target program, the commission may:

52.18 (1) evaluate and ensure that the program does not place a disproportionate burden on  
52.19 communities most impacted by health disparities, the providers who primarily serve  
52.20 communities most impacted by health disparities, or individuals who reside in rural areas  
52.21 or have high health care needs;

52.22 (2) consider payment models that help ensure financial sustainability of rural health care  
52.23 delivery systems and the ability to provide population health;

52.24 (3) consider the addition of quality of care performance measures or minimum primary  
52.25 care spending goals;

52.26 (4) allow setting growth targets that encourage an individual health care entity to serve  
52.27 populations with greater health care risks by incorporating:

52.28 (i) a risk factor adjustment reflecting the health status of the entity's patient mix; and

52.29 (ii) an equity adjustment accounting for the social determinants of health and other  
52.30 factors related to health equity for the entity's patient mix;

52.31 (5) ensure that growth targets:

53.1 (i) encourage the growth of the Minnesota health care workforce, including the need to  
53.2 provide competitive wages and benefits;

53.3 (ii) do not limit the use of collective bargaining or place a floor or ceiling on health care  
53.4 workforce compensation; and

53.5 (iii) promote workforce stability and maintain high-quality health care jobs; and

53.6 (6) consult with stakeholders representing patients, health care providers, payers of  
53.7 health care services, and others.

53.8 (b) Based on an analysis of drivers of health care spending by the commissioner and  
53.9 evidence from public testimony, the commissioner shall explore strategies and new policies,  
53.10 and future legislative proposals, that can contribute to achieving health care spending growth  
53.11 targets or limiting health care spending growth without increasing disparities in access to  
53.12 health care, including the establishment of accountability mechanisms for health care entities.

53.13 Subd. 7. Reports. (a) The commission shall submit the reports specified in this section  
53.14 to the chairs and ranking minority members of the legislative committees with primary  
53.15 jurisdiction over health care. These reports must be made available to the public.

53.16 (b) The commission shall submit written progress updates about the development and  
53.17 implementation of the health care growth target program by February 15, 2024 and February  
53.18 15, 2025. The updates must include reporting on commission membership and activities,  
53.19 program design decisions, planned timelines for implementation of the program, progress  
53.20 of implementation, and comprehensive methodological details underlying program design  
53.21 decisions.

53.22 (c) The commission shall submit by March 31, 2026, and by March 31 annually thereafter,  
53.23 reports on health care spending trends subject to the health care growth targets. The  
53.24 commission may delegate preparation of the reports to the commissioner, and any contractors  
53.25 the commissioner determines are necessary. The reports must include:

53.26 (1) aggregate spending growth for entities subject to health care growth targets relative  
53.27 to established target levels;

53.28 (2) findings from the analyses of cost drivers of health care spending growth;

53.29 (3) estimates of the impact of health care spending growth on Minnesota residents,  
53.30 including for those communities most impacted by health disparities, including an analysis  
53.31 of Minnesota residents' access to insurance and care, the value of health care, and the state's  
53.32 ability to pursue other spending priorities;

54.1 (4) the potential and observed impact of the health care growth targets on the financial  
54.2 viability of the rural health care delivery system;

54.3 (5) changes in the health care spending growth methodology under consideration; and

54.4 (6) recommended policy changes that may affect health care spending growth trends,  
54.5 including broader and more transparent adoption of value-based payment arrangements.

54.6 **Sec. 4. [62J.0414] HEALTH CARE AFFORDABILITY ADVISORY COUNCIL.**

54.7 Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions  
54.8 have the meanings given.

54.9 (b) "Council" means the Health Care Affordability Advisory Council.

54.10 (c) "Commission" means the Health Care Affordability Commission.

54.11 Subd. 2. **Establishment; administration.** (a) The commissioner of health shall appoint  
54.12 a 13-member advisory council to provide technical assistance to the commission. Members  
54.13 shall be appointed based on their knowledge and demonstrated expertise in one or more of  
54.14 the following areas:

54.15 (1) health care spending trends and drivers;

54.16 (2) equitable access to health care services;

54.17 (3) health insurance operation and finance;

54.18 (4) actuarial science;

54.19 (5) the practice of medicine;

54.20 (6) patient perspectives;

54.21 (7) clinical and health services research; and

54.22 (8) the health care marketplace.

54.23 (b) The commissioner shall provide administrative and staff support to the advisory  
54.24 council.

54.25 Subd. 3. **Membership.** The council's membership shall consist of:

54.26 (1) three members representing patients and health care consumers, at least one of whom  
54.27 must have experience working with communities most impacted by health disparities and  
54.28 one of whom must have experience working with persons in the disability community;

54.29 (2) the commissioner of health or a designee;

- 55.1 (3) the commissioner of human services or a designee;
- 55.2 (4) one member who is a health services researcher at the University of Minnesota;
- 55.3 (5) two members who represent nonprofit group purchasers;
- 55.4 (6) one member who represents for-profit group purchasers;
- 55.5 (7) two members who represent health care systems;
- 55.6 (8) one member who represents independent health care providers;
- 55.7 (9) two members who represent employee benefit plans, with one representing a public
- 55.8 employer; and
- 55.9 (10) one member who represents the Rare Disease Advisory Council.
- 55.10 Subd. 4. **Terms.** (a) The initial appointments to the council shall be made by September
- 55.11 30, 2023. The council members shall serve staggered terms of three or four years determined
- 55.12 by lot by the secretary of state. Following the initial appointments, the council members
- 55.13 shall serve four-year terms. Members may not serve more than two consecutive terms.
- 55.14 (b) Removal and vacancies of council members are governed by section 15.059.
- 55.15 Subd. 5. **Meetings.** The council must meet publicly on at least a monthly basis until the
- 55.16 initial growth targets are established. After the initial growth targets are established, the
- 55.17 council shall meet at least quarterly.
- 55.18 Subd. 6. **Duties.** The council shall:
- 55.19 (1) provide technical advice to the commission on the development and implementation
- 55.20 of the health care spending growth targets, drivers of health care spending, and other items
- 55.21 related to the commission duties;
- 55.22 (2) provide technical input on data sources for measuring health care spending; and
- 55.23 (3) advise the commission on methods to measure the impact of health care spending
- 55.24 growth targets on:
- 55.25 (i) communities most impacted by health disparities;
- 55.26 (ii) the providers who primarily serve communities most impacted by health disparities;
- 55.27 (iii) individuals with disabilities;
- 55.28 (iv) individuals with health coverage through medical assistance or MinnesotaCare;
- 55.29 (v) individuals who reside in rural areas; and

56.1 (vi) individuals with rare diseases.

56.2 Subd. 7. **Expiration.** Notwithstanding section 15.059, subdivision 6, the council does  
56.3 not expire.

56.4 Sec. 5. **[62J.0415] NOTICE TO HEALTH CARE ENTITIES.**

56.5 Subdivision 1. **Notice.** The commission shall provide notice to all health care entities  
56.6 that have been identified by the commission as exceeding the health care spending growth  
56.7 target for a specified period as determined by the commission.

56.8 Subd. 2. **Performance improvement plans.** (a) The commission shall establish and  
56.9 implement procedures to assist health care entities to improve efficiency and reduce cost  
56.10 growth by requiring some or all health care entities provided notice under subdivision 1 to  
56.11 file and implement a performance improvement plan. The commission shall provide written  
56.12 notice of this requirement to health care entities and describe the form and manner in which  
56.13 these plans must be prepared and submitted.

56.14 (b) The performance improvement plan must be filed with the commission:

56.15 (1) within 45 days of receipt of an initial notice;

56.16 (2) if the health care entity has requested a waiver or extension, within 45 days of receipt  
56.17 of a notice that the waiver or extension has been denied; or

56.18 (3) if the health care entity has been granted an extension, on the date given in the  
56.19 extension.

56.20 (c) The health care entity may file any documentation or supporting evidence with the  
56.21 commission to support the health care entity's application to waive or extend the timeline  
56.22 to file a performance improvement plan. The commission shall require the health care entity  
56.23 to submit any other relevant information it deems necessary in considering the waiver or  
56.24 extension application, provided that this information shall be made public at the discretion  
56.25 of the commission. The commission may waive or delay the requirement for a health care  
56.26 entity to file a performance improvement plan in response to a waiver or extension request  
56.27 in light of all information received from the health care entity, based on a consideration of  
56.28 the following factors:

56.29 (1) the costs, price, and utilization trends of the health care entity over time, and any  
56.30 demonstrated improvement in reducing per capita medical expenses adjusted by health  
56.31 status;

57.1 (2) any ongoing strategies or investments that the health care entity is implementing to  
57.2 improve future long-term efficiency and reduce cost growth;

57.3 (3) whether the factors that led to increased costs for the health care entity can reasonably  
57.4 be considered to be unanticipated and outside of the control of the entity. These factors may  
57.5 include but shall not be limited to age and other health status adjusted factors of the patients  
57.6 served by the health care entity and other cost inputs such as pharmaceutical expenses and  
57.7 medical device expenses;

57.8 (4) the overall financial condition of the health care entity; and

57.9 (5) any other factors the commission considers relevant.

57.10 If the commission declines to waive or extend the requirement for the health care entity to  
57.11 file a performance improvement plan, the commission shall provide written notice to the  
57.12 health care entity that its application for a waiver or extension was denied and the health  
57.13 care entity shall file a performance improvement plan.

57.14 (d) A health care entity shall file a performance improvement plan with the commission:

57.15 (1) within 45 days of receipt of an initial notice;

57.16 (2) if the health care entity has requested a waiver or extension, within 45 days of receipt  
57.17 of a notice that such waiver or extension has been denied; or

57.18 (3) if the health care entity is granted an extension, on the date given on the extension.

57.19 The performance improvement plan shall identify the causes of the entity's cost growth and  
57.20 shall include but not be limited to specific strategies, adjustments, and action steps the entity  
57.21 proposes to implement to improve cost performance. The proposed performance improvement  
57.22 plan shall include specific identifiable and measurable expected outcomes and a timetable  
57.23 for implementation. The commission may request additional information as needed, in order  
57.24 to approve a proposed performance improvement plan. The timetable for a performance  
57.25 improvement plan must not exceed 18 months.

57.26 (e) The commission shall approve any performance improvement plan that it determines  
57.27 is reasonably likely to address the underlying cause of the entity's cost growth and has a  
57.28 reasonable expectation for successful implementation. If the commission determines that  
57.29 the performance improvement plan is unacceptable or incomplete, the commission may  
57.30 provide consultation on the criteria that have not been met and may allow an additional time  
57.31 period of up to 30 calendar days for resubmission. Upon approval of the proposed  
57.32 performance improvement plan, the commission shall notify the health care entity to begin  
57.33 immediate implementation of the performance improvement plan. Public notice shall be

58.1 provided by the commission on its website, identifying that the health care entity is  
58.2 implementing a performance improvement plan. All health care entities implementing an  
58.3 approved performance improvement plan shall be subject to additional reporting requirements  
58.4 and compliance monitoring, as determined by the commission. The commission shall provide  
58.5 assistance to the health care entity in the successful implementation of the performance  
58.6 improvement plan.

58.7 (f) All health care entities shall in good faith work to implement the performance  
58.8 improvement plan. At any point during the implementation of the performance improvement  
58.9 plan, the health care entity may file amendments to the performance improvement plan,  
58.10 subject to approval of the commission. At the conclusion of the timetable established in the  
58.11 performance improvement plan, the health care entity shall report to the commission  
58.12 regarding the outcome of the performance improvement plan. If the commission determines  
58.13 the performance improvement plan was not implemented successfully, the commission  
58.14 shall:

58.15 (1) extend the implementation timetable of the existing performance improvement plan;

58.16 (2) approve amendments to the performance improvement plan as proposed by the health  
58.17 care entity;

58.18 (3) require the health care entity to submit a new performance improvement plan; or

58.19 (4) waive or delay the requirement to file any additional performance improvement  
58.20 plans.

58.21 Upon the successful completion of the performance improvement plan, the commission  
58.22 shall remove the identity of the health care entity from the commission's website.

58.23 (g) If the commission determines that a health care entity has:

58.24 (1) willfully neglected to file a performance improvement plan with the commission  
58.25 within 45 days or as required;

58.26 (2) failed to file an acceptable performance improvement plan in good faith with the  
58.27 commission;

58.28 (3) failed to implement the performance improvement plan in good faith; or

58.29 (4) knowingly failed to provide information required by this subdivision to the  
58.30 commission or knowingly provided false information, the commission may assess a civil  
58.31 penalty to the health care entity of not more than \$500,000. The commission shall only  
58.32 impose a civil penalty as a last resort.

59.1       Sec. 6. **[62J.0416] IDENTIFY STRATEGIES FOR REDUCTION OF**  
59.2 **ADMINISTRATIVE SPENDING AND LOW-VALUE CARE.**

59.3       (a) The commissioner of health shall develop recommendations for strategies to reduce  
59.4 the volume and growth of administrative spending by health care organizations and group  
59.5 purchasers, and the magnitude of low-value care delivered to Minnesota residents. The  
59.6 commissioner shall:

59.7       (1) review the availability of data and identify gaps in the data infrastructure to estimate  
59.8 aggregated and disaggregated administrative spending and low-value care;

59.9       (2) based on available data, estimate the volume and change over time of administrative  
59.10 spending and low-value care in Minnesota;

59.11       (3) conduct an environmental scan and key informant interviews with experts in health  
59.12 care finance, health economics, health care management or administration, and the  
59.13 administration of health insurance benefits to determine drivers of spending growth for  
59.14 spending on administrative services or the provision of low-value care; and

59.15       (4) convene a clinical learning community and an employer task force to review the  
59.16 evidence from clauses (1) to (3) and develop a set of actionable strategies to address  
59.17 administrative spending volume and growth and the magnitude of the volume of low-value  
59.18 care.

59.19       (b) By March 31, 2025, the commissioner shall deliver the recommendations to the  
59.20 chairs and ranking minority members of house and senate committees with jurisdiction over  
59.21 health and human services finance and policy.

59.22       Sec. 7. **[62J.0417] PAYMENT MECHANISMS IN RURAL HEALTH CARE.**

59.23       (a) The commissioner shall develop a plan to assess readiness of rural communities and  
59.24 rural health care providers to adopt value based, global budgeting or alternative payment  
59.25 systems and recommend steps needed to implement them. The commissioner may use the  
59.26 development of case studies and modeling of alternate payment systems to demonstrate  
59.27 value-based payment systems that ensure a baseline level of essential community or regional  
59.28 health services and address population health needs.

59.29       (b) The commissioner shall develop recommendations for pilot projects with the aim of  
59.30 ensuring financial viability of rural health care systems in the context of spending growth  
59.31 targets. The commissioner shall share findings with the Minnesota health care cost growth  
59.32 target commission.

60.1 Sec. 8. Minnesota Statutes 2022, section 62U.04, subdivision 11, is amended to read:

60.2 Subd. 11. **Restricted uses of the all-payer claims data.** (a) Notwithstanding subdivision  
60.3 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the commissioner's  
60.4 designee shall only use the data submitted under subdivisions 4 and 5 for the following  
60.5 purposes:

60.6 (1) to evaluate the performance of the health care home program as authorized under  
60.7 section 62U.03, subdivision 7;

60.8 (2) to study, in collaboration with the reducing avoidable readmissions effectively  
60.9 (RARE) campaign, hospital readmission trends and rates;

60.10 (3) to analyze variations in health care costs, quality, utilization, and illness burden based  
60.11 on geographical areas or populations;

60.12 (4) to evaluate the state innovation model (SIM) testing grant received by the Departments  
60.13 of Health and Human Services, including the analysis of health care cost, quality, and  
60.14 utilization baseline and trend information for targeted populations and communities; ~~and~~

60.15 (5) to compile one or more public use files of summary data or tables that must:

60.16 (i) be available to the public for no or minimal cost by March 1, 2016, and available by  
60.17 web-based electronic data download by June 30, 2019;

60.18 (ii) not identify individual patients, payers, or providers;

60.19 (iii) be updated by the commissioner, at least annually, with the most current data  
60.20 available;

60.21 (iv) contain clear and conspicuous explanations of the characteristics of the data, such  
60.22 as the dates of the data contained in the files, the absence of costs of care for uninsured  
60.23 patients or nonresidents, and other disclaimers that provide appropriate context; and

60.24 (v) not lead to the collection of additional data elements beyond what is authorized under  
60.25 this section as of June 30, 2015; and

60.26 (6) to provide technical assistance to the Health Care Affordability Commission to  
60.27 implement sections 62J.0411 to 62J.04125.

60.28 (b) The commissioner may publish the results of the authorized uses identified in  
60.29 paragraph (a) so long as the data released publicly do not contain information or descriptions  
60.30 in which the identity of individual hospitals, clinics, or other providers may be discerned.

61.1 (c) Nothing in this subdivision shall be construed to prohibit the commissioner from  
61.2 using the data collected under subdivision 4 to complete the state-based risk adjustment  
61.3 system assessment due to the legislature on October 1, 2015.

61.4 (d) The commissioner or the commissioner's designee may use the data submitted under  
61.5 subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until July 1,  
61.6 2023.

61.7 (e) The commissioner shall consult with the all-payer claims database work group  
61.8 established under subdivision 12 regarding the technical considerations necessary to create  
61.9 the public use files of summary data described in paragraph (a), clause (5).

61.10 Sec. 9. Minnesota Statutes 2022, section 62V.05, is amended by adding a subdivision to  
61.11 read:

61.12 Subd. 13. **Transitional cost-sharing reductions.** (a) The board shall develop and  
61.13 implement, for the 2024, 2025, and 2026 plan years only, a system to support eligible  
61.14 individuals who choose to enroll in gold level health plans through MNsure.

61.15 (b) For purposes of this section, an "eligible individual" is an individual who:

61.16 (1) is a resident of Minnesota; and

61.17 (2) is enrolled in a gold level health plan offered in the enrollee's county of residence.

61.18 (c) Under the system established in this subdivision, the monthly transitional cost-sharing  
61.19 reduction subsidy for an eligible individual is \$75.

61.20 (d) The board shall establish procedures for determining an individual's eligibility for  
61.21 the subsidy and providing payments to a health carrier for any eligible individuals enrolled  
61.22 in the carrier's gold level health plans.

61.23 Sec. 10. [256.9631] **DIRECT PAYMENT SYSTEM FOR MEDICAL ASSISTANCE**  
61.24 **AND MINNESOTACARE.**

61.25 Subdivision 1. **Direct payment system established.** (a) The commissioner shall establish  
61.26 a direct payment system to deliver services to eligible individuals, in order to achieve better  
61.27 health outcomes and reduce the cost of health care for the state. Under this system, eligible  
61.28 individuals shall receive services through the medical assistance fee-for-service system,  
61.29 county-based purchasing plans, or county-owned health maintenance organizations. The  
61.30 commissioner shall implement the direct payment system beginning January 1, 2027.

62.1 (b) Persons who do not meet the definition of eligible individual shall continue to receive  
62.2 services from managed care and county-based purchasing plans under sections 256B.69  
62.3 and 256B.692, subject to the opt-out provision under section 256B.69, subdivision 28,  
62.4 paragraph (c), for persons who are certified as blind or having a disability, and the exemptions  
62.5 from managed care enrollment listed in section 256B.69, subdivision 4, paragraph (b).

62.6 Subd. 2. **Definitions.** (a) For purposes of this section, the following definitions apply.

62.7 (b) "Eligible individuals" means: (1) qualified medical assistance enrollees, defined as  
62.8 persons eligible for medical assistance as families and children and adults without children  
62.9 eligible under section 256B.055, subdivision 15; and (2) all MinnesotaCare enrollees.

62.10 (c) "Qualified hospital provider" means a nonstate government teaching hospital with  
62.11 high medical assistance utilization and a level 1 trauma center, and all of the hospital's  
62.12 owned or affiliated health care professionals, ambulance services, sites, and clinics.

62.13 Subd. 3. **Managed care service delivery.** (a) In counties that choose to operate a  
62.14 county-based purchasing plan under section 256B.692, the commissioner shall permit those  
62.15 counties, in a timely manner, to establish a new county-based purchasing plan or participate  
62.16 in an existing county-based purchasing plan.

62.17 (b) In counties that choose to operate a county-owned health maintenance organization  
62.18 under section 256B.69, the commissioner shall permit those counties to establish a new  
62.19 county-owned and operated health maintenance organization or continue serving enrollees  
62.20 through an existing county-owned and operated health maintenance organization.

62.21 (c) County-based purchasing plans and county-owned health maintenance organizations  
62.22 shall be reimbursed at the capitation rate determined under sections 256B.69 and 256B.692,  
62.23 unless the county board or boards elect to receive fee-for-service reimbursement under  
62.24 subdivision 3, paragraph (b).

62.25 (d) The commissioner shall allow eligible individuals the opportunity to opt out of  
62.26 enrollment in a county-based purchasing plan or county-owned health maintenance  
62.27 organization.

62.28 Subd. 4. **Fee-for-service reimbursement.** (a) The commissioner shall reimburse health  
62.29 care providers directly for all medical assistance and MinnesotaCare covered services  
62.30 provided to eligible individuals, using the fee-for-service payment methods specified in  
62.31 chapters 256, 256B, 256R, and 256S. Payments for services shall be made to individual  
62.32 providers, clinics, and hospitals for the services they provide, and not to hospital systems  
62.33 or networks of providers.

63.1 (b) The commissioner, at the election of the county board or boards, shall directly  
63.2 reimburse participating providers of county-based purchasing plans and county-owned  
63.3 health maintenance organizations at the fee-for-service payment rate for services provided  
63.4 to eligible individuals.

63.5 (c) The commissioner shall ensure that payments under this section to a qualified hospital  
63.6 provider are equivalent to the payments that would have been received based on managed  
63.7 care direct payment arrangements. If necessary, a qualified hospital provider may use a  
63.8 county-owned health maintenance organization to receive direct payments as described in  
63.9 section 256B.1973.

63.10 Subd. 5. **Termination of managed care contracts.** The commissioner shall terminate  
63.11 managed care contracts for eligible individuals under sections 256B.69, 256L.12, and  
63.12 256L.121 by December 31, 2026, except that the commissioner may continue to contract  
63.13 with county-based purchasing plans and county-owned health maintenance organizations,  
63.14 as provided under this section.

63.15 Subd. 6. **System development and administration.** (a) The commissioner, under the  
63.16 direct payment system, shall:

63.17 (1) provide benefits management, claims processing, and enrollee support services;

63.18 (2) coordinate operation of the direct payment system with county agencies and MNsure,  
63.19 and with service delivery to medical assistance enrollees who are age 65 or older, blind, or  
63.20 have disabilities, or who are exempt from managed care enrollment under section 256B.69,  
63.21 subdivision 4, paragraph (b);

63.22 (3) establish and maintain provider payment rates at levels sufficient to ensure  
63.23 high-quality care and enrollee access to covered health care services;

63.24 (4) develop and monitor quality measures for health care service delivery; and

63.25 (5) develop and implement provider incentives and innovative methods of health care  
63.26 delivery, to ensure the efficient provision of high-quality care and reduce health care  
63.27 disparities.

63.28 (b) This section does not prohibit the commissioner from seeking legislative and federal  
63.29 approval for demonstration projects to ensure access to care or improve health care quality.

63.30 (c) The commissioner may contract with an administrator to administer the direct payment  
63.31 system.

64.1 Subd. 7. **Implementation plan.** (a) The commissioner shall present an implementation  
64.2 plan for the direct payment system to the chairs and ranking minority members of the  
64.3 legislative committees with jurisdiction over health care policy and finance by January 15,  
64.4 2025. The commissioner may contract for technical assistance in developing the  
64.5 implementation plan and conducting related studies and analysis.

64.6 (b) The implementation plan must include:

64.7 (1) a timeline for the development and implementation of the direct payment system;

64.8 (2) the procedures to be used to ensure continuity of care for enrollees who transition  
64.9 from managed care to fee-for-service;

64.10 (3) any changes to fee-for-service payment rates that the commissioner determines are  
64.11 necessary to ensure provider access and high-quality care, and reduce health disparities;

64.12 (4) recommendations on providing effective care coordination under the direct payment  
64.13 system for all enrollees, including those with complex medical conditions, who face  
64.14 socioeconomic barriers to receiving care, or who are from underserved populations that  
64.15 experience health disparities;

64.16 (5) recommendations on whether the direct payment system should include supplemental  
64.17 payments for care coordination, including:

64.18 (i) the provider types eligible for supplemental payments and funding for outreach;

64.19 (ii) procedures to coordinate supplemental payments with existing supplemental or  
64.20 cost-based payment methods; and

64.21 (iii) procedures to align care coordination initiatives funded through supplemental  
64.22 payments under this section with existing care coordination initiatives;

64.23 (6) recommendations on whether the direct payment system should include funding to  
64.24 providers for outreach initiatives to patients who, because of mental illness, homelessness,  
64.25 or other circumstances, are unlikely to obtain needed care and treatment;

64.26 (7) recommendations on whether and how the direct payment system should be expanded  
64.27 to deliver services and care coordination under medical assistance to persons who are blind  
64.28 or have a disability, and managed care contracts to deliver services to these individuals;

64.29 (8) procedures to compensate providers for any loss of savings from the federal 340B  
64.30 Drug Pricing Program; and

64.31 (9) recommendations for statutory changes necessary to implement the direct payment  
64.32 system.

65.1 (c) In developing the implementation plan, the commissioner shall:

65.2 (1) calculate the projected cost of a direct payment system relative to the cost of the  
65.3 current system;

65.4 (2) assess gaps in care coordination under the current medical assistance and  
65.5 MinnesotaCare programs;

65.6 (3) evaluate the effectiveness of approaches other states have taken to coordinate care  
65.7 under a fee-for-service system, including the coordination of care provided to persons who  
65.8 are blind or have disabilities;

65.9 (4) estimate the loss in provider financial savings under the federal 340B Drug Pricing  
65.10 Program that would result from the elimination of managed care plan contracts under medical  
65.11 assistance and MinnesotaCare, and develop a method to reimburse providers for these  
65.12 potential losses;

65.13 (5) consult with the commissioner of health and the contractor or contractors analyzing  
65.14 the Minnesota Health Plan and other reform models, on plan design and assumptions; and

65.15 (6) conduct other analyses necessary to develop the implementation plan.

65.16 Sec. 11. Minnesota Statutes 2022, section 256.969, subdivision 9, is amended to read:

65.17 **Subd. 9. Disproportionate numbers of low-income patients served.** (a) For admissions  
65.18 occurring on or after July 1, 1993, the medical assistance disproportionate population  
65.19 adjustment shall comply with federal law and shall be paid to a hospital, excluding regional  
65.20 treatment centers and facilities of the federal Indian Health Service, with a medical assistance  
65.21 inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined  
65.22 as follows:

65.23 (1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic  
65.24 mean for all hospitals excluding regional treatment centers and facilities of the federal Indian  
65.25 Health Service but less than or equal to one standard deviation above the mean, the  
65.26 adjustment must be determined by multiplying the total of the operating and property  
65.27 payment rates by the difference between the hospital's actual medical assistance inpatient  
65.28 utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers  
65.29 and facilities of the federal Indian Health Service; and

65.30 (2) for a hospital with a medical assistance inpatient utilization rate above one standard  
65.31 deviation above the mean, the adjustment must be determined by multiplying the adjustment  
65.32 that would be determined under clause (1) for that hospital by 1.1. The commissioner shall

66.1 report annually on the number of hospitals likely to receive the adjustment authorized by  
66.2 this paragraph. The commissioner shall specifically report on the adjustments received by  
66.3 public hospitals and public hospital corporations located in cities of the first class.

66.4 (b) Certified public expenditures made by Hennepin County Medical Center shall be  
66.5 considered Medicaid disproportionate share hospital payments. Hennepin County and  
66.6 Hennepin County Medical Center shall report by June 15, 2007, on payments made beginning  
66.7 July 1, 2005, or another date specified by the commissioner, that may qualify for  
66.8 reimbursement under federal law. Based on these reports, the commissioner shall apply for  
66.9 federal matching funds.

66.10 (c) Upon federal approval of the related state plan amendment, paragraph (b) is effective  
66.11 retroactively from July 1, 2005, or the earliest effective date approved by the Centers for  
66.12 Medicare and Medicaid Services.

66.13 (d) Effective July 1, 2015, disproportionate share hospital (DSH) payments shall be paid  
66.14 in accordance with a new methodology using 2012 as the base year. Annual payments made  
66.15 under this paragraph shall equal the total amount of payments made for 2012. A licensed  
66.16 children's hospital shall receive only a single DSH factor for children's hospitals. Other  
66.17 DSH factors may be combined to arrive at a single factor for each hospital that is eligible  
66.18 for DSH payments. The new methodology shall make payments only to hospitals located  
66.19 in Minnesota and include the following factors:

66.20 (1) a licensed children's hospital with at least 1,000 fee-for-service discharges in the  
66.21 base year shall receive a factor of 0.868. A licensed children's hospital with less than 1,000  
66.22 fee-for-service discharges in the base year shall receive a factor of 0.7880;

66.23 (2) a hospital that has in effect for the initial rate year a contract with the commissioner  
66.24 to provide extended psychiatric inpatient services under section 256.9693 shall receive a  
66.25 factor of 0.0160;

66.26 (3) a hospital that has received medical assistance payment for at least 20 transplant  
66.27 services in the base year shall receive a factor of 0.0435;

66.28 (4) a hospital that has a medical assistance utilization rate in the base year between 20  
66.29 percent up to one standard deviation above the statewide mean utilization rate shall receive  
66.30 a factor of 0.0468;

66.31 (5) a hospital that has a medical assistance utilization rate in the base year that is at least  
66.32 one standard deviation above the statewide mean utilization rate but is less than two and  
66.33 one-half standard deviations above the mean shall receive a factor of 0.2300; and

67.1 (6) a hospital that is a level one trauma center and that has a medical assistance utilization  
67.2 rate in the base year that is at least two and one-half standard deviations above the statewide  
67.3 mean utilization rate shall receive a factor of 0.3711.

67.4 (e) For the purposes of determining eligibility for the disproportionate share hospital  
67.5 factors in paragraph (d), clauses (1) to (6), the medical assistance utilization rate and  
67.6 discharge thresholds shall be measured using only one year when a two-year base period  
67.7 is used.

67.8 (f) Any payments or portion of payments made to a hospital under this subdivision that  
67.9 are subsequently returned to the commissioner because the payments are found to exceed  
67.10 the hospital-specific DSH limit for that hospital shall be redistributed, proportionate to the  
67.11 number of fee-for-service discharges, to other DSH-eligible non-children's hospitals that  
67.12 have a medical assistance utilization rate that is at least one standard deviation above the  
67.13 mean.

67.14 (g) An additional payment adjustment shall be established by the commissioner under  
67.15 this subdivision for a hospital that provides high levels of administering high-cost drugs to  
67.16 enrollees in fee-for-service medical assistance. The commissioner shall consider factors  
67.17 including fee-for-service medical assistance utilization rates and payments made for drugs  
67.18 purchased through the 340B drug purchasing program and administered to fee-for-service  
67.19 enrollees. If any part of this adjustment exceeds a hospital's hospital-specific disproportionate  
67.20 share hospital limit, or if the hospital qualifies for the alternative payment rate described in  
67.21 subdivision 2e, the commissioner shall make a payment to the hospital that equals the  
67.22 nonfederal share of the amount that exceeds the limit. The total nonfederal share of the  
67.23 amount of the payment adjustment under this paragraph shall not exceed ~~\$1,500,000~~ \$.....

67.24 **EFFECTIVE DATE.** This section is effective January 1, 2026, or the January 1  
67.25 following certification of the modernized pharmacy claims processing system, whichever  
67.26 is later.

67.27 Sec. 12. Minnesota Statutes 2022, section 256B.056, subdivision 7, is amended to read:

67.28 Subd. 7. **Period of eligibility.** (a) Eligibility is available for the month of application  
67.29 and for three months prior to application if the person was eligible in those prior months.  
67.30 A redetermination of eligibility must occur every 12 months.

67.31 (b) Notwithstanding any other law to the contrary:

67.32 (1) a child under 19 years of age who is determined eligible for medical assistance must  
67.33 remain eligible for a period of 12 months;

68.1 (2) a child 19 years of age and older but under 21 years of age who is determined eligible  
68.2 for medical assistance must remain eligible for a period of 12 months; and

68.3 (3) a child under six years of age who is determined eligible for medical assistance must  
68.4 remain eligible through the month in which the child reaches six years of age.

68.5 (c) A child's eligibility under paragraph (b) may be terminated earlier if:

68.6 (1) the child or the child's representative requests voluntary termination of eligibility;

68.7 (2) the child ceases to be a resident of this state;

68.8 (3) the child dies; or

68.9 (4) the agency determines eligibility was erroneously granted at the most recent eligibility  
68.10 determination due to agency error or fraud, abuse, or perjury attributed to the child or the  
68.11 child's representative.

68.12 ~~(b)~~ (d) For a person eligible for an insurance affordability program as defined in section  
68.13 256B.02, subdivision 19, who reports a change that makes the person eligible for medical  
68.14 assistance, eligibility is available for the month the change was reported and for three months  
68.15 prior to the month the change was reported, if the person was eligible in those prior months.

68.16 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,  
68.17 whichever is later, except that paragraph (b), clause (1), is effective January 1, 2024. The  
68.18 commissioner of human services shall notify the revisor of statutes when federal approval  
68.19 is obtained.

68.20 Sec. 13. Minnesota Statutes 2022, section 256B.0625, subdivision 18h, is amended to  
68.21 read:

68.22 Subd. 18h. **Managed care.** (a) The following subdivisions apply to managed care plans  
68.23 and county-based purchasing plans:

68.24 (1) subdivision 17, paragraphs (a), (b), (i), and (n);

68.25 (2) subdivision 18; and

68.26 (3) subdivision 18a.

68.27 (b) A nonemergency medical transportation provider must comply with the operating  
68.28 standards for special transportation service specified in sections 174.29 to 174.30 and  
68.29 Minnesota Rules, chapter 8840. Publicly operated transit systems, volunteers, and not-for-hire  
68.30 vehicles are exempt from the requirements in this paragraph.

69.1 (c) Managed care plans and county-based purchasing plans shall reimburse pharmacies  
69.2 for drug costs at a level not to exceed the reimbursement rate in subdivision 13e, paragraphs  
69.3 (a), (d), and (f), excluding the 340B drug program ceiling price limit, and shall pay a  
69.4 dispensing fee equal to the fee-for-service dispensing fee in subdivision 13e, paragraph (a),  
69.5 for outpatient drugs dispensed to enrollees. Contracts between managed care plans and  
69.6 county-based purchasing plans and providers to whom this paragraph applies must allow  
69.7 recovery of payments from those providers if capitation rates are adjusted in accordance  
69.8 with this paragraph. Payment recoveries must not exceed an amount equal to any increase  
69.9 in rates that results from this provision. This paragraph shall not be implemented if federal  
69.10 approval is not received for this paragraph, or if federal approval is withdrawn at any time.

69.11 **EFFECTIVE DATE.** This section is effective January 1, 2024, or upon federal approval,  
69.12 whichever is later.

69.13 Sec. 14. Minnesota Statutes 2022, section 256B.0631, subdivision 1, is amended to read:

69.14 Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical  
69.15 assistance benefit plan shall include the following cost-sharing for all recipients, effective  
69.16 for services provided ~~on or after~~ from September 1, 2011, to December 31, 2023:

69.17 (1) \$3 per nonpreventive visit, except as provided in paragraph (b). For purposes of this  
69.18 subdivision, a visit means an episode of service which is required because of a recipient's  
69.19 symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting  
69.20 by a physician or physician assistant, chiropractor, podiatrist, nurse midwife, advanced  
69.21 practice nurse, audiologist, optician, or optometrist;

69.22 (2) \$3.50 for nonemergency visits to a hospital-based emergency room, except that this  
69.23 co-payment shall be increased to \$20 upon federal approval;

69.24 (3) \$3 per brand-name drug prescription, \$1 per generic drug prescription, and \$1 per  
69.25 prescription for a brand-name multisource drug listed in preferred status on the preferred  
69.26 drug list, subject to a \$12 per month maximum for prescription drug co-payments. No  
69.27 co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness;

69.28 (4) a family deductible equal to \$2.75 per month per family and adjusted annually by  
69.29 the percentage increase in the medical care component of the CPI-U for the period of  
69.30 September to September of the preceding calendar year, rounded to the next higher five-cent  
69.31 increment; and

69.32 (5) total monthly cost-sharing must not exceed five percent of family income. For  
69.33 purposes of this paragraph, family income is the total earned and unearned income of the

70.1 individual and the individual's spouse, if the spouse is enrolled in medical assistance and  
70.2 also subject to the five percent limit on cost-sharing. This paragraph does not apply to  
70.3 premiums charged to individuals described under section 256B.057, subdivision 9.

70.4 (b) Recipients of medical assistance are responsible for all co-payments and deductibles  
70.5 in this subdivision.

70.6 (c) Notwithstanding paragraph (b), the commissioner, through the contracting process  
70.7 under sections 256B.69 and 256B.692, may allow managed care plans and county-based  
70.8 purchasing plans to waive the family deductible under paragraph (a), clause (4). The value  
70.9 of the family deductible shall not be included in the capitation payment to managed care  
70.10 plans and county-based purchasing plans. Managed care plans and county-based purchasing  
70.11 plans shall certify annually to the commissioner the dollar value of the family deductible.

70.12 (d) Notwithstanding paragraph (b), the commissioner may waive the collection of the  
70.13 family deductible described under paragraph (a), clause (4), from individuals and allow  
70.14 long-term care and waived service providers to assume responsibility for payment.

70.15 (e) Notwithstanding paragraph (b), the commissioner, through the contracting process  
70.16 under section 256B.0756 shall allow the pilot program in Hennepin County to waive  
70.17 co-payments. The value of the co-payments shall not be included in the capitation payment  
70.18 amount to the integrated health care delivery networks under the pilot program.

70.19 (f) For services provided on or after January 1, 2024, the medical assistance benefit plan  
70.20 must not include cost-sharing or deductibles for any medical assistance recipient or benefit.

70.21 Sec. 15. Minnesota Statutes 2022, section 256B.0631, subdivision 3, is amended to read:

70.22 Subd. 3. **Collection.** (a) The medical assistance reimbursement to the provider shall be  
70.23 reduced by the amount of the co-payment or deductible, except that reimbursements shall  
70.24 not be reduced:

70.25 (1) once a recipient has reached the \$12 per month maximum for prescription drug  
70.26 co-payments; or

70.27 (2) for a recipient who has met their monthly five percent cost-sharing limit.

70.28 (b) The provider collects the co-payment or deductible from the recipient. Providers  
70.29 may not deny services to recipients who are unable to pay the co-payment or deductible.

70.30 ~~(c) Medical assistance reimbursement to fee-for-service providers and payments to~~  
70.31 ~~managed care plans shall not be increased as a result of the removal of co-payments or~~  
70.32 ~~deductibles effective on or after January 1, 2009.~~

71.1 **EFFECTIVE DATE.** This section is effective January 1, 2024.

71.2 Sec. 16. Minnesota Statutes 2022, section 256B.69, subdivision 4, is amended to read:

71.3 Subd. 4. **Limitation of choice; opportunity to opt out.** (a) The commissioner shall  
71.4 develop criteria to determine when limitation of choice may be implemented in the  
71.5 experimental counties, but shall provide all eligible individuals the opportunity to opt out  
71.6 of enrollment in managed care under this section. The criteria shall ensure that all eligible  
71.7 individuals in the county have continuing access to the full range of medical assistance  
71.8 services as specified in subdivision 6.

71.9 (b) The commissioner shall exempt the following persons from participation in the  
71.10 project, in addition to those who do not meet the criteria for limitation of choice:

71.11 (1) persons eligible for medical assistance according to section 256B.055, subdivision  
71.12 1;

71.13 (2) persons eligible for medical assistance due to blindness or disability as determined  
71.14 by the Social Security Administration or the state medical review team, unless:

71.15 (i) they are 65 years of age or older; or

71.16 (ii) they reside in Itasca County or they reside in a county in which the commissioner  
71.17 conducts a pilot project under a waiver granted pursuant to section 1115 of the Social  
71.18 Security Act;

71.19 (3) recipients who currently have private coverage through a health maintenance  
71.20 organization;

71.21 (4) recipients who are eligible for medical assistance by spending down excess income  
71.22 for medical expenses other than the nursing facility per diem expense;

71.23 (5) recipients who receive benefits under the Refugee Assistance Program, established  
71.24 under United States Code, title 8, section 1522(e);

71.25 (6) children who are both determined to be severely emotionally disturbed and receiving  
71.26 case management services according to section 256B.0625, subdivision 20, except children  
71.27 who are eligible for and who decline enrollment in an approved preferred integrated network  
71.28 under section 245.4682;

71.29 (7) adults who are both determined to be seriously and persistently mentally ill and  
71.30 received case management services according to section 256B.0625, subdivision 20;

72.1 (8) persons eligible for medical assistance according to section 256B.057, subdivision  
72.2 10;

72.3 (9) persons with access to cost-effective employer-sponsored private health insurance  
72.4 or persons enrolled in a non-Medicare individual health plan determined to be cost-effective  
72.5 according to section 256B.0625, subdivision 15; and

72.6 (10) persons who are absent from the state for more than 30 consecutive days but still  
72.7 deemed a resident of Minnesota, identified in accordance with section 256B.056, subdivision  
72.8 1, paragraph (b).

72.9 Children under age 21 who are in foster placement may enroll in the project on an elective  
72.10 basis. Individuals excluded under clauses (1), (6), and (7) may choose to enroll on an elective  
72.11 basis. The commissioner may enroll recipients in the prepaid medical assistance program  
72.12 for seniors who are (1) age 65 and over, and (2) eligible for medical assistance by spending  
72.13 down excess income.

72.14 (c) The commissioner may allow persons with a one-month spenddown who are otherwise  
72.15 eligible to enroll to voluntarily enroll or remain enrolled, if they elect to prepay their monthly  
72.16 spenddown to the state.

72.17 (d) The commissioner may require, subject to the opt-out provision under paragraph (a),  
72.18 those individuals to enroll in the prepaid medical assistance program who otherwise would  
72.19 have been excluded under paragraph (b), clauses (1), (3), and (8), and under Minnesota  
72.20 Rules, part 9500.1452, subpart 2, items H, K, and L.

72.21 (e) Before limitation of choice is implemented, eligible individuals shall be notified and  
72.22 given the opportunity to opt out of managed care enrollment. After notification, those  
72.23 individuals who choose not to opt out shall be allowed to choose only among demonstration  
72.24 providers. The commissioner may assign an individual with private coverage through a  
72.25 health maintenance organization, to the same health maintenance organization for medical  
72.26 assistance coverage, if the health maintenance organization is under contract for medical  
72.27 assistance in the individual's county of residence. After initially choosing a provider, the  
72.28 recipient is allowed to change that choice only at specified times as allowed by the  
72.29 commissioner. If a demonstration provider ends participation in the project for any reason,  
72.30 a recipient enrolled with that provider must select a new provider but may change providers  
72.31 without cause once more within the first 60 days after enrollment with the second provider.

72.32 (f) An infant born to a woman who is eligible for and receiving medical assistance and  
72.33 who is enrolled in the prepaid medical assistance program shall be retroactively enrolled to  
72.34 the month of birth in the same managed care plan as the mother once the child is enrolled

73.1 in medical assistance unless the child is determined to be excluded from enrollment in a  
73.2 prepaid plan under this section.

73.3 **EFFECTIVE DATE.** This section is effective January 1, 2024.

73.4 Sec. 17. Minnesota Statutes 2022, section 256B.69, subdivision 6d, is amended to read:

73.5 Subd. 6d. **Prescription drugs.** The commissioner ~~may~~ shall exclude or modify coverage  
73.6 for outpatient prescription drugs dispensed by a pharmacy to a medical assistance or  
73.7 MinnesotaCare enrollee from the prepaid managed care contracts entered into under this  
73.8 ~~section in order to increase savings to the state by collecting additional prescription drug~~  
73.9 ~~rebates. The contracts must maintain incentives for the managed care plan to manage drug~~  
73.10 ~~costs and utilization and may require that the managed care plans maintain an open drug~~  
73.11 ~~formulary. In order to manage drug costs and utilization, the contracts may authorize the~~  
73.12 ~~managed care plans to use preferred drug lists and prior authorization. This subdivision is~~  
73.13 ~~contingent on federal approval of the managed care contract changes and the collection of~~  
73.14 ~~additional prescription drug rebates~~ chapter and chapter 256L. The commissioner may  
73.15 include, exclude, or modify coverage for prescription drugs administered to a medical  
73.16 assistance or MinnesotaCare enrollee from the prepaid managed care contracts entered into  
73.17 under this chapter and chapter 256L.

73.18 **EFFECTIVE DATE.** This section is effective January 1, 2026, or the January 1  
73.19 following certification of the modernized pharmacy claims processing system, whichever  
73.20 is later.

73.21 Sec. 18. Minnesota Statutes 2022, section 256B.69, subdivision 28, is amended to read:

73.22 Subd. 28. **Medicare special needs plans; medical assistance basic health care.** (a)  
73.23 The commissioner may contract with demonstration providers and current or former sponsors  
73.24 of qualified Medicare-approved special needs plans, to provide medical assistance basic  
73.25 health care services to persons with disabilities, including those with developmental  
73.26 disabilities. Basic health care services include:

73.27 (1) those services covered by the medical assistance state plan except for ICF/DD services,  
73.28 home and community-based waiver services, case management for persons with  
73.29 developmental disabilities under section 256B.0625, subdivision 20a, and personal care and  
73.30 certain home care services defined by the commissioner in consultation with the stakeholder  
73.31 group established under paragraph (d); and

74.1 (2) basic health care services may also include risk for up to 100 days of nursing facility  
74.2 services for persons who reside in a noninstitutional setting and home health services related  
74.3 to rehabilitation as defined by the commissioner after consultation with the stakeholder  
74.4 group.

74.5 The commissioner may exclude other medical assistance services from the basic health  
74.6 care benefit set. Enrollees in these plans can access any excluded services on the same basis  
74.7 as other medical assistance recipients who have not enrolled.

74.8 (b) The commissioner may contract with demonstration providers and current and former  
74.9 sponsors of qualified Medicare special needs plans, to provide basic health care services  
74.10 under medical assistance to persons who are dually eligible for both Medicare and Medicaid  
74.11 and those Social Security beneficiaries eligible for Medicaid but in the waiting period for  
74.12 Medicare. The commissioner shall consult with the stakeholder group under paragraph (d)  
74.13 in developing program specifications for these services. Payment for Medicaid services  
74.14 provided under this subdivision for the months of May and June will be made no earlier  
74.15 than July 1 of the same calendar year.

74.16 (c) ~~Notwithstanding subdivision 4, beginning January 1, 2012,~~ The commissioner shall  
74.17 enroll persons with disabilities in managed care under this section, unless the individual  
74.18 chooses to opt out of enrollment. The commissioner shall establish enrollment and opt out  
74.19 procedures consistent with applicable enrollment procedures under this section.

74.20 (d) The commissioner shall establish a state-level stakeholder group to provide advice  
74.21 on managed care programs for persons with disabilities, including both MnDHO and contracts  
74.22 with special needs plans that provide basic health care services as described in paragraphs  
74.23 (a) and (b). The stakeholder group shall provide advice on program expansions under this  
74.24 subdivision and subdivision 23, including:

74.25 (1) implementation efforts;

74.26 (2) consumer protections; and

74.27 (3) program specifications such as quality assurance measures, data collection and  
74.28 reporting, and evaluation of costs, quality, and results.

74.29 (e) Each plan under contract to provide medical assistance basic health care services  
74.30 shall establish a local or regional stakeholder group, including representatives of the counties  
74.31 covered by the plan, members, consumer advocates, and providers, for advice on issues that  
74.32 arise in the local or regional area.

75.1 (f) The commissioner is prohibited from providing the names of potential enrollees to  
75.2 health plans for marketing purposes. The commissioner shall mail no more than two sets  
75.3 of marketing materials per contract year to potential enrollees on behalf of health plans, at  
75.4 the health plan's request. The marketing materials shall be mailed by the commissioner  
75.5 within 30 days of receipt of these materials from the health plan. The health plans shall  
75.6 cover any costs incurred by the commissioner for mailing marketing materials.

75.7 **EFFECTIVE DATE.** This section is effective January 1, 2024.

75.8 Sec. 19. Minnesota Statutes 2022, section 256B.69, subdivision 36, is amended to read:

75.9 Subd. 36. **Enrollee support system.** (a) The commissioner shall establish an enrollee  
75.10 support system that provides support to an enrollee before and during enrollment in a  
75.11 managed care plan.

75.12 (b) The enrollee support system must:

75.13 (1) provide access to counseling for each potential enrollee on choosing a managed care  
75.14 plan or opting out of managed care;

75.15 (2) assist an enrollee in understanding enrollment in a managed care plan;

75.16 (3) provide an access point for complaints regarding enrollment, covered services, and  
75.17 other related matters;

75.18 (4) provide information on an enrollee's grievance and appeal rights within the managed  
75.19 care organization and the state's fair hearing process, including an enrollee's rights and  
75.20 responsibilities; and

75.21 (5) provide assistance to an enrollee, upon request, in navigating the grievance and  
75.22 appeals process within the managed care organization and in appealing adverse benefit  
75.23 determinations made by the managed care organization to the state's fair hearing process  
75.24 after the managed care organization's internal appeals process has been exhausted. Assistance  
75.25 does not include providing representation to an enrollee at the state's fair hearing, but may  
75.26 include a referral to appropriate legal representation sources.

75.27 (c) Outreach to enrollees through the support system must be accessible to an enrollee  
75.28 through multiple formats, including telephone, Internet, in-person, and, if requested, through  
75.29 auxiliary aids and services.

75.30 (d) The commissioner may designate enrollment brokers to assist enrollees on selecting  
75.31 a managed care organization and providing necessary enrollment information. For purposes  
75.32 of this subdivision, "enrollment broker" means an individual or entity that performs choice

76.1 counseling or enrollment activities in accordance with Code of Federal Regulations, part  
76.2 42, section 438.810, or both.

76.3 **EFFECTIVE DATE.** This section is effective January 1, 2024.

76.4 Sec. 20. Minnesota Statutes 2022, section 256B.692, subdivision 1, is amended to read:

76.5 Subdivision 1. **In general.** County boards or groups of county boards may elect to  
76.6 purchase or provide health care services on behalf of persons eligible for medical assistance  
76.7 who would otherwise be required to or may elect to participate in the prepaid medical  
76.8 assistance program according to section 256B.69, subject to the opt-out provision of section  
76.9 256B.69, subdivision 4, paragraph (a). Counties that elect to purchase or provide health  
76.10 care under this section must provide all services included in prepaid managed care programs  
76.11 according to section 256B.69, subdivisions 1 to 22. County-based purchasing under this  
76.12 section is governed by section 256B.69, unless otherwise provided for under this section.

76.13 **EFFECTIVE DATE.** This section is effective January 1, 2024.

76.14 Sec. 21. Minnesota Statutes 2022, section 256B.75, is amended to read:

76.15 **256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.**

76.16 (a) For outpatient hospital facility fee payments for services rendered on or after October  
76.17 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge,  
76.18 or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for  
76.19 which there is a federal maximum allowable payment. Effective for services rendered on  
76.20 or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and  
76.21 emergency room facility fees shall be increased by eight percent over the rates in effect on  
76.22 December 31, 1999, except for those services for which there is a federal maximum allowable  
76.23 payment. Services for which there is a federal maximum allowable payment shall be paid  
76.24 at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total  
76.25 aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare  
76.26 upper limit. If it is determined that a provision of this section conflicts with existing or  
76.27 future requirements of the United States government with respect to federal financial  
76.28 participation in medical assistance, the federal requirements prevail. The commissioner  
76.29 may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial  
76.30 participation resulting from rates that are in excess of the Medicare upper limitations.

76.31 (b) (1) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory  
76.32 surgery hospital facility fee services for critical access hospitals designated under section

77.1 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the  
77.2 cost-finding methods and allowable costs of the Medicare program. Effective for services  
77.3 provided on or after July 1, 2015, rates established for critical access hospitals under this  
77.4 paragraph for the applicable payment year shall be the final payment and shall not be settled  
77.5 to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal  
77.6 year ending in 2017, the rate for outpatient hospital services shall be computed using  
77.7 information from each hospital's Medicare cost report as filed with Medicare for the year  
77.8 that is two years before the year that the rate is being computed. Rates shall be computed  
77.9 using information from Worksheet C series until the department finalizes the medical  
77.10 assistance cost reporting process for critical access hospitals. After the cost reporting process  
77.11 is finalized, rates shall be computed using information from Title XIX Worksheet D series.  
77.12 The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs  
77.13 related to rural health clinics and federally qualified health clinics, divided by ancillary  
77.14 charges plus outpatient charges, excluding charges related to rural health clinics and federally  
77.15 qualified health clinics.

77.16 (2) The rate described in clause (1) shall be increased for hospitals providing high levels  
77.17 of 340B drugs. The rate adjustment shall be based on each hospital's share of the total  
77.18 reimbursement for 340B drugs to all critical access hospitals, but shall not exceed ....  
77.19 percentage points.

77.20 (c) Effective for services provided on or after July 1, 2003, rates that are based on the  
77.21 Medicare outpatient prospective payment system shall be replaced by a budget neutral  
77.22 prospective payment system that is derived using medical assistance data. The commissioner  
77.23 shall provide a proposal to the 2003 legislature to define and implement this provision.  
77.24 When implementing prospective payment methodologies, the commissioner shall use general  
77.25 methods and rate calculation parameters similar to the applicable Medicare prospective  
77.26 payment systems for services delivered in outpatient hospital and ambulatory surgical center  
77.27 settings unless other payment methodologies for these services are specified in this chapter.

77.28 (d) For fee-for-service services provided on or after July 1, 2002, the total payment,  
77.29 before third-party liability and spenddown, made to hospitals for outpatient hospital facility  
77.30 services is reduced by .5 percent from the current statutory rate.

77.31 (e) In addition to the reduction in paragraph (d), the total payment for fee-for-service  
77.32 services provided on or after July 1, 2003, made to hospitals for outpatient hospital facility  
77.33 services before third-party liability and spenddown, is reduced five percent from the current  
77.34 statutory rates. Facilities defined under section 256.969, subdivision 16, are excluded from  
77.35 this paragraph.

78.1 (f) In addition to the reductions in paragraphs (d) and (e), the total payment for  
78.2 fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient  
78.3 hospital facility services before third-party liability and spenddown, is reduced three percent  
78.4 from the current statutory rates. Mental health services and facilities defined under section  
78.5 256.969, subdivision 16, are excluded from this paragraph.

78.6 **EFFECTIVE DATE.** This section is effective January 1, 2026, or the January 1  
78.7 following certification of the modernized pharmacy claims processing system, whichever  
78.8 is later.

78.9 Sec. 22. Minnesota Statutes 2022, section 256L.04, subdivision 1c, is amended to read:

78.10 Subd. 1c. **General requirements.** To be eligible for MinnesotaCare, a person must meet  
78.11 the eligibility requirements of this section. A person eligible for MinnesotaCare ~~shall~~ with  
78.12 a family income of less than or equal to 200 percent of the federal poverty guidelines must  
78.13 not be considered a qualified individual under section 1312 of the Affordable Care Act, and  
78.14 is not eligible for enrollment in a qualified health plan offered through MNsure under chapter  
78.15 62V.

78.16 **EFFECTIVE DATE.** This section is effective January 1, 2027, or upon federal approval,  
78.17 whichever is later. The commissioner of human services shall notify the revisor of statutes  
78.18 when federal approval is obtained.

78.19 Sec. 23. Minnesota Statutes 2022, section 256L.04, subdivision 7a, is amended to read:

78.20 Subd. 7a. **Ineligibility.** Adults whose income is greater than the limits established under  
78.21 this section may not enroll in the MinnesotaCare program, except as provided in subdivision  
78.22 15.

78.23 **EFFECTIVE DATE.** This section is effective January 1, 2027, or upon federal approval,  
78.24 whichever is later. The commissioner of human services shall notify the revisor of statutes  
78.25 when federal approval is obtained.

78.26 Sec. 24. Minnesota Statutes 2022, section 256L.04, subdivision 10, is amended to read:

78.27 Subd. 10. **Citizenship requirements.** (a) Eligibility for MinnesotaCare is ~~limited~~  
78.28 available to citizens or nationals of the United States ~~and~~,<sup>2</sup> lawfully present noncitizens as  
78.29 defined in Code of Federal Regulations, title 8, section 103.12~~;~~, and undocumented  
78.30 noncitizens ~~are ineligible for MinnesotaCare~~. For purposes of this subdivision, an  
78.31 undocumented noncitizen is an individual who resides in the United States without the  
78.32 approval or acquiescence of the United States Citizenship and Immigration Services. Families

79.1 with children who are citizens or nationals of the United States must cooperate in obtaining  
79.2 satisfactory documentary evidence of citizenship or nationality according to the requirements  
79.3 of the federal Deficit Reduction Act of 2005, Public Law 109-171.

79.4 (b) Notwithstanding subdivisions 1 and 7, eligible persons include families and  
79.5 individuals who are ~~lawfully present and~~ ineligible for medical assistance by reason of  
79.6 immigration status and who have incomes equal to or less than 200 percent of federal poverty  
79.7 guidelines.

79.8 **EFFECTIVE DATE.** This section is effective January 1, 2025.

79.9 Sec. 25. Minnesota Statutes 2022, section 256L.04, is amended by adding a subdivision  
79.10 to read:

79.11 **Subd. 15. Persons eligible for public option.** (a) Families and individuals with income  
79.12 above the maximum income eligibility limit specified in subdivision 1 or 7 but who meet  
79.13 all other MinnesotaCare eligibility requirements are eligible for MinnesotaCare. All other  
79.14 provisions of this chapter apply unless otherwise specified.

79.15 (b) Families and individuals may enroll in MinnesotaCare under this subdivision only  
79.16 during an annual open enrollment period or special enrollment period, as designated by  
79.17 MNSure in compliance with Code of Federal Regulations, title 45, parts 155.410 and 155.420.

79.18 **EFFECTIVE DATE.** This section is effective January 1, 2027, or upon federal approval,  
79.19 whichever is later. The commissioner of human services shall notify the revisor of statutes  
79.20 when federal approval is obtained.

79.21 Sec. 26. Minnesota Statutes 2022, section 256L.07, subdivision 1, is amended to read:

79.22 Subdivision 1. **General requirements.** Individuals enrolled in MinnesotaCare under  
79.23 section 256L.04, subdivision 1, and individuals enrolled in MinnesotaCare under section  
79.24 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty  
79.25 guidelines; are no longer eligible for the program and ~~shall~~ must be disenrolled by the  
79.26 commissioner, unless the individuals continue MinnesotaCare enrollment through the public  
79.27 option under section 256L.04, subdivision 15. For persons disenrolled under this subdivision,  
79.28 MinnesotaCare coverage terminates the last day of the calendar month in which the  
79.29 commissioner sends advance notice according to Code of Federal Regulations, title 42,  
79.30 section 431.211, that indicates the income of a family or individual exceeds program income  
79.31 limits.

80.1 **EFFECTIVE DATE.** This section is effective January 1, 2027, or upon federal approval,  
 80.2 whichever is later. The commissioner of human services shall notify the revisor of statutes  
 80.3 when federal approval is obtained.

80.4 Sec. 27. Minnesota Statutes 2022, section 256L.15, subdivision 2, is amended to read:

80.5 Subd. 2. **Sliding fee scale; monthly individual or family income.** (a) The commissioner  
 80.6 shall establish a sliding fee scale to determine the percentage of monthly individual or family  
 80.7 income that households at different income levels must pay to obtain coverage through the  
 80.8 MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly  
 80.9 individual or family income.

80.10 ~~(b) Beginning January 1, 2014, MinnesotaCare enrollees shall pay premiums according~~  
 80.11 ~~to the premium scale specified in paragraph (d).~~

80.12 ~~(e) (b) Paragraph (b) (a) does not apply to:~~

80.13 ~~(1) children 20 years of age or younger; and~~

80.14 ~~(2) individuals with household incomes below 35 percent of the federal poverty~~  
 80.15 ~~guidelines.~~

80.16 ~~(d) The following premium scale is established for each individual in the household who~~  
 80.17 ~~is 21 years of age or older and enrolled in MinnesotaCare:~~

80.18	<b>Federal Poverty Guideline</b>	<b>Less than</b>	<b>Individual Premium</b>
80.19	<b>Greater than or Equal to</b>		<b>Amount</b>
80.20	35%	55%	\$4
80.21	55%	80%	\$6
80.22	80%	90%	\$8
80.23	90%	100%	\$10
80.24	100%	110%	\$12
80.25	110%	120%	\$14
80.26	120%	130%	\$15
80.27	130%	140%	\$16
80.28	140%	150%	\$25
80.29	150%	160%	\$37
80.30	160%	170%	\$44
80.31	170%	180%	\$52
80.32	180%	190%	\$61
80.33	190%	200%	\$71
80.34	200%		\$80

81.1 (e) (c) Beginning January 1, 2021 2024, the commissioner shall continue to charge  
81.2 premiums in accordance with the simplified premium scale established to comply with the  
81.3 American Rescue Plan Act of 2021, in effect from January 1, 2021, through December 31,  
81.4 2025, for families and individuals eligible under section 256L.04, subdivisions 1 and 7. The  
81.5 commissioner shall adjust the premium scale established under paragraph (d) as needed to  
81.6 ensure that premiums do not exceed the amount that an individual would have been required  
81.7 to pay if the individual was enrolled in an applicable benchmark plan in accordance with  
81.8 the Code of Federal Regulations, title 42, section 600.505 (a)(1).

81.9 (d) The commissioner shall establish a sliding premium scale for persons eligible through  
81.10 the public option under section 256L.04, subdivision 15. Beginning January 1, 2027, persons  
81.11 eligible through the public option shall pay premiums according to this premium scale.  
81.12 Persons eligible through the public option who are 20 years of age or younger are exempt  
81.13 from paying premiums.

81.14 **EFFECTIVE DATE.** This section is effective January 1, 2024, except that paragraph  
81.15 (d) is effective January 1, 2027, or upon federal approval, whichever is later. The  
81.16 commissioner of human services shall notify the revisor of statutes when federal approval  
81.17 is obtained.

81.18 **Sec. 28. TRANSITION TO MINNESOTACARE PUBLIC OPTION.**

81.19 (a) The commissioner of human services shall continue to administer MinnesotaCare  
81.20 as a basic health program in accordance with Minnesota Statutes, section 256L.02,  
81.21 subdivision 5.

81.22 (b) The commissioner shall present an implementation plan for the MinnesotaCare public  
81.23 option under Minnesota Statutes, section 256L.04, subdivision 15, to the chairs and ranking  
81.24 minority members of the legislative committees with jurisdiction over health care policy  
81.25 and finance by January 15, 2025. The plan must include:

81.26 (1) recommendations for any changes to the MinnesotaCare public option necessary to  
81.27 continue federal basic health program funding or to receive other federal funding;

81.28 (2) recommendations for ensuring sufficient provider participation in MinnesotaCare;

81.29 (3) estimates of state costs related to the MinnesotaCare public option;

81.30 (4) a description of the proposed premium scale for persons eligible through the public  
81.31 option, including an analysis of the extent to which the proposed premium scale:

82.1 (i) ensures affordable premiums for persons across the income spectrum enrolled under  
82.2 the public option; and

82.3 (ii) avoids premium cliffs for persons transitioning to and enrolled under the public  
82.4 option; and

82.5 (5) draft legislation that includes any additional policy and conforming changes necessary  
82.6 to implement the MinnesotaCare public option and the implementation plan  
82.7 recommendations.

82.8 **EFFECTIVE DATE.** This section is effective the day following final enactment.

82.9 Sec. 29. **REQUEST FOR FEDERAL APPROVAL.**

82.10 (a) The commissioner of human services shall seek any federal waivers, approvals, and  
82.11 law changes necessary to implement this act, including but not limited to those waivers,  
82.12 approvals, and law changes necessary to allow the state to:

82.13 (1) continue receiving federal basic health program payments for basic health  
82.14 program-eligible MinnesotaCare enrollees and to receive other federal funding for the  
82.15 MinnesotaCare public option;

82.16 (2) receive federal payments equal to the value of premium tax credits and cost-sharing  
82.17 reductions that MinnesotaCare enrollees with household incomes greater than 200 percent  
82.18 of the federal poverty guidelines would otherwise have received; and

82.19 (3) receive federal payments equal to the value of emergency medical assistance that  
82.20 would otherwise have been paid to the state for covered services provided to eligible  
82.21 enrollees.

82.22 (b) In implementing this section, the commissioner of human services shall consult with  
82.23 the commissioner of commerce and the Board of Directors of MNsure and may contract  
82.24 for technical and actuarial assistance.

82.25 **EFFECTIVE DATE.** This section is effective the day following final enactment.

82.26 Sec. 30. **ANALYSIS OF BENEFITS AND COSTS OF UNIVERSAL HEALTH CARE**  
82.27 **SYSTEM REFORM MODELS.**

82.28 Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have  
82.29 the meanings given.

82.30 (b) "All necessary care" means the full range of services listed in the proposed Minnesota  
82.31 Health Plan legislation, including medical, dental, vision and hearing, mental health, chemical

83.1 dependency treatment, reproductive and sexual health, prescription drugs, medical equipment  
83.2 and supplies, long-term care, home care, and coordination of care.

83.3 (c) "Direct payment system" means the health care delivery system authorized by  
83.4 Minnesota Statutes, section 256.9631.

83.5 (d) "MinnesotaCare public option" means the MinnesotaCare expansion to cover  
83.6 individuals eligible under Minnesota Statutes, section 256L.04, subdivision 15.

83.7 (e) "Other reform models" means alternative models of health care reform, that may  
83.8 include changes to health system administration, payments, or benefits, and may be  
83.9 comprehensive or specific to selected market segments or populations.

83.10 (f) "Total public and private health care spending" means:

83.11 (1) spending on all medical care including but not limited to dental, vision and hearing,  
83.12 mental health, chemical dependency treatment, prescription drugs, medical equipment and  
83.13 supplies, long-term care, and home care, whether paid through premiums, co-pays and  
83.14 deductibles, other out-of-pocket payments, or other funding from government, employers,  
83.15 or other sources; and

83.16 (2) the costs associated with administering, delivering, and paying for the care. The costs  
83.17 of administering, delivering, and paying for the care includes all expenses by insurers,  
83.18 providers, employers, individuals, and government to select, negotiate, purchase, and  
83.19 administer insurance and care including but not limited to coverage for health care, dental,  
83.20 long-term care, prescription drugs, and the medical expense portions of workers compensation  
83.21 and automobile insurance, and the cost of administering and paying for all health care  
83.22 products and services that are not covered by insurance.

83.23 Subd. 2. **Initial assumptions.** (a) When calculating administrative savings under the  
83.24 universal health proposal, the analysts shall recognize that simple, direct payment of medical  
83.25 services avoids the need for provider networks, eliminates prior authorization requirements,  
83.26 and eliminates administrative complexity of other payment schemes along with the need  
83.27 for creating risk adjustment mechanisms, and measuring, tracking, and paying under those  
83.28 risk adjusted or nonrisk adjusted payment schemes by both providers and payors.

83.29 (b) The analysts shall assume that, under the universal health proposal, while gross  
83.30 provider payments may be reduced to reflect reduced administrative costs, net provider  
83.31 income would remain similar to the current system. However, they shall not assume that  
83.32 payment rate negotiations will track current Medicaid, Medicare, or market payment rates  
83.33 or a combination of those rates, because provider compensation, after adjusting for reduced

84.1 administrative costs, would not be universally raised or lowered but would be negotiated  
84.2 based on market needs, so provider compensation might be raised in an underserved area  
84.3 such as mental health but lowered in other areas.

84.4 Subd. 3. **Contract for analysis of proposals; analytic tool.** (a) The commissioner of  
84.5 health shall contract with one or more independent entities to:

84.6 (1) conduct an analysis of the benefits and costs of a legislative proposal for a universal  
84.7 health care financing system, based on the legislative proposal known as the Minnesota  
84.8 Health Plan (Regular Session 2022, Senate File No. 2740/House File No. 2798) and a similar  
84.9 analysis of the current health care financing system to assist the state in comparing the  
84.10 proposal to the current system; and

84.11 (2) conduct an analysis of the MinnesotaCare public option, the direct payment system,  
84.12 and other reform models, and a similar analysis of the current health care financing system  
84.13 to assist the state in comparing the models to the current system.

84.14 (b) In conducting these analyses, the contractor or contractors shall develop and use an  
84.15 analytic tool that meets the requirements in subdivision 4, and shall also make this analytic  
84.16 tool available for use by the commissioner.

84.17 (c) The commissioner shall issue a request for information. Based on responses to the  
84.18 request for information, the commissioner shall issue a request for proposals that specifies  
84.19 requirements for the design, analysis, and deliverables, and shall select one or more  
84.20 contractors based on responses to the request for proposals. The commissioner shall consult  
84.21 with the chief authors of this act in implementing this paragraph.

84.22 Subd. 4. **Requirements for analytic tool.** (a) The analytic tool must be able to assess  
84.23 and model the impact of the Minnesota Health Plan, the direct payment system, the  
84.24 MinnesotaCare public option, and other reform models on the following:

84.25 (1) coverage: the number of people who are uninsured versus the number of people who  
84.26 are insured;

84.27 (2) benefit completeness: adequacy of coverage measured by the completeness of the  
84.28 coverage and the number of people lacking coverage for key necessary care elements such  
84.29 as dental, long-term care, medical equipment or supplies, vision and hearing, or other health  
84.30 services that are not covered, if any. The analysis must take into account the vast variety of  
84.31 benefit designs in the commercial market and report the extent of coverage in each area;

85.1 (3) underinsurance: whether people with coverage can afford the care they need or  
85.2 whether cost prevents them from accessing care. This includes affordability in terms of  
85.3 premiums, deductibles, and out-of-pocket expenses;

85.4 (4) system capacity: the timeliness and appropriateness of the care received and whether  
85.5 people turn to inappropriate care such as emergency rooms because of a lack of proper care  
85.6 in accordance with clinical guidelines; and

85.7 (5) health care spending: total public and private health care spending in Minnesota,  
85.8 including all spending by individuals, businesses, and government. Where relevant, the  
85.9 analysis shall be broken out by key necessary care areas, such as medical, dental, and mental  
85.10 health. The analysis of total health care spending shall examine whether there are savings  
85.11 or additional costs under the legislative proposal compared to the existing system due to:

85.12 (i) changes in cost of insurance, billing, underwriting, marketing, evaluation, and other  
85.13 administrative functions for all entities involved in the health care system, including savings  
85.14 from global budgeting for hospitals and institutional care instead of billing for individual  
85.15 services provided;

85.16 (ii) changed prices on medical services and products, including pharmaceuticals, due to  
85.17 price negotiations under the proposal;

85.18 (iii) impact on utilization, health outcomes, and workplace absenteeism due to prevention,  
85.19 early intervention, and health-promoting activities;

85.20 (iv) shortages or excess capacity of medical facilities, equipment, and personnel, including  
85.21 caregivers and staff, under either the current system or the proposal, including capacity of  
85.22 clinics, hospitals, and other appropriate care sites versus inappropriate emergency room  
85.23 usage. The analysis shall break down capacity by geographic differences such as rural versus  
85.24 metro, and disparate access by population group;

85.25 (v) the impact on state, local, and federal government non-health-care expenditures.  
85.26 This may include areas such as reduced crime and out-of-home placement costs due to  
85.27 mental health or chemical dependency coverage. Additional definition may further develop  
85.28 hypotheses for other impacts that warrant analysis;

85.29 (vi) job losses or gains within the health care system; specifically, in health care delivery,  
85.30 health billing, and insurance administration;

85.31 (vii) job losses or gains elsewhere in the economy under the proposal due to  
85.32 implementation of the resulting reduction of insurance and administrative burdens on  
85.33 businesses; and

86.1 (viii) impacts on disparities in health care access and outcomes.

86.2 (b) The analytic tool must:

86.3 (1) have the capacity to conduct interactive microsimulations;

86.4 (2) allow comparisons between the Minnesota Health Plan, the direct payment system,  
86.5 the MinnesotaCare public option, the current delivery system, and other reform models, on  
86.6 the relative impact of these delivery approaches on the variables described in paragraph (a);  
86.7 and

86.8 (3) allow comparisons based on differing assumptions about the characteristics and  
86.9 operation of the delivery approaches.

86.10 Subd. 5. **Analyses by the commissioner.** The commissioner, in cooperation with the  
86.11 commissioners of human services and commerce, and the legislature, may use the analytic  
86.12 tool to assist in the development, design, and analysis of reform models under consideration  
86.13 by the legislature and state agencies, and to supplement the analyses of the Minnesota Health  
86.14 Plan, the MinnesotaCare public option, and the direct payment system conducted by the  
86.15 contractor or contractors under this section.

86.16 Subd. 6. **Report and delivery of analytic tool.** (a) The contractor or contractors, by  
86.17 January 15, 2026, shall report findings and recommendations to the commissioner, and to  
86.18 the chairs and ranking minority members of the legislative committees with jurisdiction  
86.19 over health care and commerce, on the design and implementation of the Minnesota Health  
86.20 Plan, the MinnesotaCare public option, and the direct payment system. The findings and  
86.21 recommendations must address the feasibility and affordability of the proposals, and the  
86.22 projected impact of the proposals on the variables listed in subdivision 4.

86.23 (b) The contractor or contractors shall make the analytic tool available to the  
86.24 commissioner by January 15, 2026.

### 86.25 **ARTICLE 3**

#### 86.26 **DEPARTMENT OF HEALTH**

86.27 Section 1. Minnesota Statutes 2022, section 12A.08, subdivision 3, is amended to read:

86.28 Subd. 3. **Implementation.** To implement the requirements of this section, the  
86.29 commissioner may cooperate with private health care providers and facilities, Tribal nations,  
86.30 and community health boards as defined in section 145A.02; provide grants to assist  
86.31 community health boards; and Tribal nations; use volunteer services of individuals qualified

87.1 to provide public health services; and enter into cooperative or mutual aid agreements to  
87.2 provide public health services.

87.3 Sec. 2. Minnesota Statutes 2022, section 13.3805, subdivision 1, is amended to read:

87.4 Subdivision 1. **Health data generally.** (a) **Definitions.** As used in this subdivision:

87.5 (1) "Commissioner" means the commissioner of health.

87.6 (2) "Health data" are data on individuals created, collected, received, or maintained by  
87.7 the Department of Health, political subdivisions, or statewide systems relating to the  
87.8 identification, description, prevention, and control of disease or as part of an epidemiologic  
87.9 investigation the commissioner designates as necessary to analyze, describe, or protect the  
87.10 public health.

87.11 (b) **Data on individuals.** (1) Health data are private data on individuals. Notwithstanding  
87.12 section 13.05, subdivision 9, health data may not be disclosed except as provided in this  
87.13 subdivision and section 13.04.

87.14 (2) The commissioner or a community health board as defined in section 145A.02,  
87.15 subdivision 5, may disclose health data to the data subject's physician as necessary to locate  
87.16 or identify a case, carrier, or suspect case, to establish a diagnosis, to provide treatment, to  
87.17 identify persons at risk of illness, or to conduct an epidemiologic investigation.

87.18 (3) With the approval of the commissioner, health data may be disclosed to the extent  
87.19 necessary to assist the commissioner to locate or identify a case, carrier, or suspect case, to  
87.20 alert persons who may be threatened by illness as evidenced by epidemiologic data, to  
87.21 control or prevent the spread of serious disease, or to diminish an imminent threat to the  
87.22 public health.

87.23 ~~(e) **Health summary data.** Summary data derived from data collected under section~~  
87.24 ~~145.413 may be provided under section 13.05, subdivision 7.~~

87.25 **EFFECTIVE DATE.** This section is effective the day following final enactment.

87.26 Sec. 3. Minnesota Statutes 2022, section 16A.151, subdivision 2, is amended to read:

87.27 Subd. 2. **Exceptions.** (a) If a state official litigates or settles a matter on behalf of specific  
87.28 injured persons or entities, this section does not prohibit distribution of money to the specific  
87.29 injured persons or entities on whose behalf the litigation or settlement efforts were initiated.  
87.30 If money recovered on behalf of injured persons or entities cannot reasonably be distributed  
87.31 to those persons or entities because they cannot readily be located or identified or because

88.1 the cost of distributing the money would outweigh the benefit to the persons or entities, the  
88.2 money must be paid into the general fund.

88.3 (b) Money recovered on behalf of a fund in the state treasury other than the general fund  
88.4 may be deposited in that fund.

88.5 (c) This section does not prohibit a state official from distributing money to a person or  
88.6 entity other than the state in litigation or potential litigation in which the state is a defendant  
88.7 or potential defendant.

88.8 (d) State agencies may accept funds as directed by a federal court for any restitution or  
88.9 monetary penalty under United States Code, title 18, section 3663(a)(3), or United States  
88.10 Code, title 18, section 3663A(a)(3). Funds received must be deposited in a special revenue  
88.11 account and are appropriated to the commissioner of the agency for the purpose as directed  
88.12 by the federal court.

88.13 (e) Tobacco settlement revenues as defined in section 16A.98, subdivision 1, paragraph  
88.14 (t), may be deposited as provided in section 16A.98, subdivision 12.

88.15 (f) Any money received by the state resulting from a settlement agreement or an assurance  
88.16 of discontinuance entered into by the attorney general of the state, or a court order in litigation  
88.17 brought by the attorney general of the state, on behalf of the state or a state agency, related  
88.18 to alleged violations of consumer fraud laws in the marketing, sale, or distribution of opioids  
88.19 in this state or other alleged illegal actions that contributed to the excessive use of opioids,  
88.20 must be deposited in the settlement account established in the opiate epidemic response  
88.21 fund under section 256.043, subdivision 1. This paragraph does not apply to attorney fees  
88.22 and costs awarded to the state or the Attorney General's Office, to contract attorneys hired  
88.23 by the state or Attorney General's Office, or to other state agency attorneys.

88.24 (g) Notwithstanding paragraph (f), if money is received from a settlement agreement or  
88.25 an assurance of discontinuance entered into by the attorney general of the state or a court  
88.26 order in litigation brought by the attorney general of the state on behalf of the state or a state  
88.27 agency against a consulting firm working for an opioid manufacturer or opioid wholesale  
88.28 drug distributor, the commissioner shall deposit any money received into the settlement  
88.29 account established within the opiate epidemic response fund under section 256.042,  
88.30 subdivision 1. Notwithstanding section 256.043, subdivision 3a, paragraph (a), any amount  
88.31 deposited into the settlement account in accordance with this paragraph shall be appropriated  
88.32 to the commissioner of human services to award as grants as specified by the opiate epidemic  
88.33 response advisory council in accordance with section 256.043, subdivision 3a, paragraph  
88.34 (d).

89.1 (h) Any money received by the state resulting from a settlement agreement or an assurance  
89.2 of discontinuance entered into by the attorney general of the state, or a court order in litigation  
89.3 brought by the attorney general of the state on behalf of the state or a state agency related  
89.4 to alleged violations of consumer fraud laws in the marketing, sale, or distribution of  
89.5 electronic nicotine delivery systems in this state or other alleged illegal actions that  
89.6 contributed to the exacerbation of youth nicotine use, must be deposited in the settlement  
89.7 account established in the tobacco use prevention account under section 144.398. This  
89.8 paragraph does not apply to: (1) attorney fees and costs awarded or paid to the state or the  
89.9 Attorney General's Office; (2) contract attorneys hired by the state or Attorney General's  
89.10 Office; or (3) other state agency attorneys.

89.11 **EFFECTIVE DATE.** This section is effective the day following final enactment.

89.12 Sec. 4. Minnesota Statutes 2022, section 62J.17, subdivision 5a, is amended to read:

89.13 Subd. 5a. **Retrospective review.** (a) The commissioner shall retrospectively review  
89.14 each major spending commitment and ~~notify the provider of the results of the review. The~~  
89.15 ~~commissioner shall~~ determine whether the major spending commitment was appropriate.  
89.16 In making the determination, the commissioner may consider the following criteria: the  
89.17 major spending commitment's impact on the cost, access, and quality of health care; the  
89.18 clinical effectiveness and cost-effectiveness of the major spending commitment; and the  
89.19 alternatives available to the provider. If the major expenditure is determined not to be  
89.20 appropriate, the commissioner shall notify the provider.

89.21 (b) The commissioner may not prevent or prohibit a major spending commitment subject  
89.22 to retrospective review. However, if the provider fails the retrospective review, any major  
89.23 spending commitments by that provider for the five-year period following the commissioner's  
89.24 decision are subject to prospective review under subdivision 6a.

89.25 Sec. 5. [62J.571] STATEWIDE HEALTH CARE PROVIDER DIRECTORY.

89.26 Subdivision 1. Definitions. (a) For the purposes of this section, the following terms have  
89.27 the meanings given.

89.28 (b) "Health care provider directory" means an electronic catalog and index that supports  
89.29 management of health care provider information, both individual and organizational, in a  
89.30 directory structure for public use to find available providers and networks and support state  
89.31 agency responsibilities.

90.1 (c) "Health care provider" means a practicing provider that accepts reimbursement from  
90.2 a group purchaser.

90.3 (d) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

90.4 Subd. 2. **Health care provider directory.** (a) The commissioner shall assess the  
90.5 feasibility and stakeholder commitment to develop, manage, and maintain a statewide  
90.6 electronic directory of health care providers. The assessment must take into consideration  
90.7 consumer information needs; state agency applications; stakeholder needs; technical  
90.8 requirements; alignment with national standards; governance; operations; legal and policy  
90.9 considerations; and existing directories.

90.10 Subd. 3. **Consultation.** The commissioner shall assess the feasibility of the directory in  
90.11 consultation with stakeholders, including but not limited to consumers, group purchasers,  
90.12 health care providers, community health boards, and state agencies.

90.13 Sec. 6. **[62J.811] PROVIDER BALANCE BILLING REQUIREMENTS.**

90.14 Subdivision 1. **Billing requirements.** (a) Each health care provider and health facility  
90.15 shall comply with Consolidated Appropriations Act, 2021, Division BB also known as the  
90.16 "No Surprises Act," including any federal regulations adopted under that act.

90.17 (b) For the purposes of this section, "provider" or "facility" means any health care  
90.18 provider or facility pursuant to section 62A.63, subdivision 2, or 62J.03, subdivision 8, that  
90.19 is subject to relevant provisions of the No Surprises Act.

90.20 Subd. 2. **Investigations and compliance.** (a) The commissioner shall, to the extent  
90.21 practicable, seek the cooperation of health care providers and facilities, and may provide  
90.22 any support and assistance as available, in obtaining compliance with this section.

90.23 (b) The commissioner shall determine the manner and processes for fulfilling any  
90.24 responsibilities and taking any of the actions in paragraphs (c) to (f).

90.25 (c) A person who believes a health care provider or facility has not complied with the  
90.26 requirements of the No Surprises Act or this section may file a complaint with the  
90.27 commissioner in the manner determined by the commissioner.

90.28 (d) The commissioner shall conduct compliance reviews and investigate complaints  
90.29 filed under this section in the manner determined by the commissioner to ascertain whether  
90.30 health care providers and facilities are complying with this section.

90.31 (e) The commissioner may report violations under this section to other relevant federal  
90.32 and state departments and jurisdictions as appropriate, including the attorney general and

91.1 relevant health-related licensing boards, and may also coordinate investigations and  
 91.2 enforcement of this section with other relevant federal and state departments and jurisdictions  
 91.3 as appropriate, including the attorney general and relevant health-related licensing boards.

91.4 (f) A health care provider or facility may contest whether the finding of facts constitute  
 91.5 a violation of this section according to the contested case proceeding in sections 14.57 to  
 91.6 14.62, subject to appeal according to sections 14.63 to 14.68.

91.7 (g) Any data collected by the commissioner as part of an active investigation or active  
 91.8 compliance review under this section are classified as protected nonpublic data pursuant to  
 91.9 section 13.02, subdivision 13, in the case of data not on individuals and confidential pursuant  
 91.10 to section 13.02, subdivision 3, in the case of data on individuals. Data describing the final  
 91.11 disposition of an investigation or compliance review are classified as public.

91.12 Subd. 3. **Civil penalty.** (a) The commissioner, in monitoring and enforcing this section,  
 91.13 may levy a civil monetary penalty against each health care provider or facility found to be  
 91.14 in violation of up to \$100 for each violation, but the penalties levied under this subdivision  
 91.15 may not exceed \$25,000 for identical violations during a calendar year.

91.16 (b) No civil monetary penalty shall be imposed under this section for violations that  
 91.17 occur prior to January 1, 2024.

91.18 Sec. 7. Minnesota Statutes 2022, section 62J.84, subdivision 2, is amended to read:

91.19 Subd. 2. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision  
 91.20 have the meanings given.

91.21 (b) "Biosimilar" means a drug that is produced or distributed pursuant to a biologics  
 91.22 license application approved under United States Code, title 42, section 262(K)(3).

91.23 (c) "Brand name drug" means a drug that is produced or distributed pursuant to:

91.24 (1) ~~an original,~~ a new drug application approved under United States Code, title 21,  
 91.25 section 355(c), except for a generic drug as defined under Code of Federal Regulations,  
 91.26 title 42, section 447.502; or

91.27 (2) a biologics license application approved under United States Code, title ~~45~~42, section  
 91.28 262(a)(c).

91.29 (d) "Commissioner" means the commissioner of health.

91.30 (e) "Generic drug" means a drug that is marketed or distributed pursuant to:

92.1 (1) an abbreviated new drug application approved under United States Code, title 21,  
92.2 section 355(j);

92.3 (2) an authorized generic as defined under Code of Federal Regulations, title ~~45~~ 42,  
92.4 section 447.502; or

92.5 (3) a drug that entered the market the year before 1962 and was not originally marketed  
92.6 under a new drug application.

92.7 (f) "Manufacturer" means a drug manufacturer licensed under section 151.252.

92.8 (g) "New prescription drug" or "new drug" means a prescription drug approved for  
92.9 marketing by the United States Food and Drug Administration (FDA) for which no previous  
92.10 wholesale acquisition cost has been established for comparison.

92.11 (h) "Patient assistance program" means a program that a manufacturer offers to the public  
92.12 in which a consumer may reduce the consumer's out-of-pocket costs for prescription drugs  
92.13 by using coupons, discount cards, prepaid gift cards, manufacturer debit cards, or by other  
92.14 means.

92.15 (i) "Prescription drug" or "drug" has the meaning provided in section 151.441, subdivision  
92.16 8.

92.17 (j) "Price" means the wholesale acquisition cost as defined in United States Code, title  
92.18 42, section 1395w-3a(c)(6)(B).

92.19 (k) "30-day supply" means the total daily dosage units of a prescription drug  
92.20 recommended by the prescribing label approved by the FDA for 30 days. If the  
92.21 FDA-approved prescribing label includes more than one recommended daily dosage, the  
92.22 30-day supply is based on the maximum recommended daily dosage on the FDA-approved  
92.23 prescribing label.

92.24 (l) "Course of treatment" means the total dosage of a single prescription for a prescription  
92.25 drug recommended by the FDA-approved prescribing label. If the FDA-approved prescribing  
92.26 label includes more than one recommended dosage for a single course of treatment, the  
92.27 course of treatment is the maximum recommended dosage on the FDA-approved prescribing  
92.28 label.

92.29 (m) "Drug product family" means a group of one or more prescription drugs that share  
92.30 a unique generic drug description or nontrade name and dosage form.

92.31 (n) "National drug code" means the three-segment code maintained by the federal Food  
92.32 and Drug Administration that includes a labeler code, a product code, and a package code

93.1 for a drug product and that has been converted to an 11-digit format consisting of five digits  
93.2 in the first segment, four digits in the second segment, and two digits in the third segment.  
93.3 A three-segment code shall be considered converted to an 11-digit format when, as necessary,  
93.4 at least one "0" has been added to the front of each segment containing less than the specified  
93.5 number of digits such that each segment contains the specified number of digits.

93.6 (o) "Pharmacy" or "pharmacy provider" means a place of business licensed by the Board  
93.7 of Pharmacy under section 151.19 in which prescription drugs are prepared, compounded,  
93.8 or dispensed under the supervision of a pharmacist.

93.9 (p) "Pharmacy benefit manager" or "PBM" means an entity licensed to act as a pharmacy  
93.10 benefit manager under section 62W.03.

93.11 (q) "Pricing unit" means the smallest dispensable amount of a prescription drug product  
93.12 that could be dispensed.

93.13 (r) "Reporting entity" means any manufacturer, pharmacy, pharmacy benefit manager,  
93.14 wholesale drug distributor, or any other entity required to submit data under this section.

93.15 (s) "Wholesale drug distributor" or "wholesaler" means an entity that:

93.16 (1) is licensed to act as a wholesale drug distributor under section 151.47; and

93.17 (2) distributes prescription drugs, of which it is not the manufacturer, to persons or  
93.18 entities, or both, other than a consumer or patient in the state.

93.19 Sec. 8. Minnesota Statutes 2022, section 62J.84, subdivision 3, is amended to read:

93.20 Subd. 3. **Prescription drug price increases reporting.** (a) Beginning January 1, 2022,  
93.21 a drug manufacturer must submit to the commissioner the information described in paragraph  
93.22 (b) for each prescription drug for which the price was \$100 or greater for a 30-day supply  
93.23 or for a course of treatment lasting less than 30 days and:

93.24 (1) for brand name drugs where there is an increase of ten percent or greater in the price  
93.25 over the previous 12-month period or an increase of 16 percent or greater in the price over  
93.26 the previous 24-month period; and

93.27 (2) for generic or biosimilar drugs where there is an increase of 50 percent or greater in  
93.28 the price over the previous 12-month period.

93.29 (b) For each of the drugs described in paragraph (a), the manufacturer shall submit to  
93.30 the commissioner no later than 60 days after the price increase goes into effect, in the form  
93.31 and manner prescribed by the commissioner, the following information, if applicable:

- 94.1 (1) the ~~name~~ description and price of the drug and the net increase, expressed as a  
94.2 percentage; with the following listed separately:
- 94.3 (i) the national drug code;
- 94.4 (ii) the product name;
- 94.5 (iii) the dosage form;
- 94.6 (iv) the strength;
- 94.7 (v) the package size;
- 94.8 (2) the factors that contributed to the price increase;
- 94.9 (3) the name of any generic version of the prescription drug available on the market;
- 94.10 (4) the introductory price of the prescription drug when it was ~~approved for marketing~~  
94.11 ~~by the Food and Drug Administration and the net yearly increase, by calendar year, in the~~  
94.12 ~~price of the prescription drug during the previous five years~~ introduced for sale in the United  
94.13 States and the price of the drug on the last day of each of the five calendar years preceding  
94.14 the price increase;
- 94.15 (5) the direct costs incurred during the previous 12-month period by the manufacturer  
94.16 that are associated with the prescription drug, listed separately:
- 94.17 (i) to manufacture the prescription drug;
- 94.18 (ii) to market the prescription drug, including advertising costs; and
- 94.19 (iii) to distribute the prescription drug;
- 94.20 (6) the total sales revenue for the prescription drug during the previous 12-month period;
- 94.21 (7) the manufacturer's net profit attributable to the prescription drug during the previous  
94.22 12-month period;
- 94.23 (8) the total amount of financial assistance the manufacturer has provided through patient  
94.24 prescription assistance programs during the previous 12-month period, if applicable;
- 94.25 (9) any agreement between a manufacturer and another entity contingent upon any delay  
94.26 in offering to market a generic version of the prescription drug;
- 94.27 (10) the patent expiration date of the prescription drug if it is under patent;
- 94.28 (11) the name and location of the company that manufactured the drug; ~~and~~
- 94.29 (12) if a brand name prescription drug, the ~~ten highest prices~~ price paid for the  
94.30 prescription drug during the previous calendar year in ~~any country other than~~ the ten

95.1 countries, excluding the United States., that charged the highest single price for the  
95.2 prescription drug; and

95.3 (13) if the prescription drug was acquired by the manufacturer during the previous  
95.4 12-month period, all of the following information:

95.5 (i) price at acquisition;

95.6 (ii) price in the calendar year prior to acquisition;

95.7 (iii) name of the company from which the drug was acquired;

95.8 (iv) date of acquisition; and

95.9 (v) acquisition price.

95.10 (c) The manufacturer may submit any documentation necessary to support the information  
95.11 reported under this subdivision.

95.12 Sec. 9. Minnesota Statutes 2022, section 62J.84, subdivision 4, is amended to read:

95.13 Subd. 4. **New prescription drug price reporting.** (a) Beginning January 1, 2022, no  
95.14 later than 60 days after a manufacturer introduces a new prescription drug for sale in the  
95.15 United States that is a new brand name drug with a price that is greater than the tier threshold  
95.16 established by the Centers for Medicare and Medicaid Services for specialty drugs in the  
95.17 Medicare Part D program for a 30-day supply or for a course of treatment lasting fewer than  
95.18 30 days or a new generic or biosimilar drug with a price that is greater than the tier threshold  
95.19 established by the Centers for Medicare and Medicaid Services for specialty drugs in the  
95.20 Medicare Part D program for a 30-day supply or for a course of treatment lasting fewer than  
95.21 30 days and is not at least 15 percent lower than the referenced brand name drug when the  
95.22 generic or biosimilar drug is launched, the manufacturer must submit to the commissioner,  
95.23 in the form and manner prescribed by the commissioner, the following information, if  
95.24 applicable:

95.25 (1) the description of the drug, with the following listed separately:

95.26 (i) the national drug code;

95.27 (ii) the product name;

95.28 (iii) the dosage form;

95.29 (iv) the strength;

95.30 (v) the package size;

- 96.1 ~~(1)~~ (2) the price of the prescription drug;
- 96.2 ~~(2)~~ (3) whether the Food and Drug Administration granted the new prescription drug a  
96.3 breakthrough therapy designation or a priority review;
- 96.4 ~~(3)~~ (4) the direct costs incurred by the manufacturer that are associated with the  
96.5 prescription drug, listed separately:
- 96.6 (i) to manufacture the prescription drug;
- 96.7 (ii) to market the prescription drug, including advertising costs; and
- 96.8 (iii) to distribute the prescription drug; and
- 96.9 ~~(4)~~ (5) the patent expiration date of the drug if it is under patent.
- 96.10 (b) The manufacturer may submit documentation necessary to support the information  
96.11 reported under this subdivision.

96.12 Sec. 10. Minnesota Statutes 2022, section 62J.84, subdivision 6, is amended to read:

96.13 Subd. 6. **Public posting of prescription drug price information.** (a) The commissioner  
96.14 shall post on the department's website, or may contract with a private entity or consortium  
96.15 that satisfies the standards of section 62U.04, subdivision 6, to meet this requirement, the  
96.16 following information:

96.17 (1) a list of the prescription drugs reported under subdivisions 3, 4, and ~~5~~, 11 to 14 and  
96.18 the manufacturers of those prescription drugs; and

96.19 (2) information reported to the commissioner under subdivisions 3, 4, and ~~5~~ 11 to 14.

96.20 (b) The information must be published in an easy-to-read format and in a manner that  
96.21 identifies the information that is disclosed on a per-drug basis and must not be aggregated  
96.22 in a manner that prevents the identification of the prescription drug.

96.23 (c) The commissioner shall not post to the department's website or a private entity  
96.24 contracting with the commissioner shall not post any information described in this section  
96.25 if the information is not public data under section 13.02, subdivision 8a; or is trade secret  
96.26 information under section 13.37, subdivision 1, paragraph (b); or is trade secret information  
96.27 pursuant to the Defend Trade Secrets Act of 2016, United States Code, title 18, section  
96.28 1836, as amended. If a manufacturer believes information should be withheld from public  
96.29 disclosure pursuant to this paragraph, the manufacturer must clearly and specifically identify  
96.30 that information and describe the legal basis in writing when the manufacturer submits the  
96.31 information under this section. If the commissioner disagrees with the manufacturer's request

97.1 to withhold information from public disclosure, the commissioner shall provide the  
97.2 manufacturer written notice that the information will be publicly posted 30 days after the  
97.3 date of the notice.

97.4 (d) If the commissioner withholds any information from public disclosure pursuant to  
97.5 this subdivision, the commissioner shall post to the department's website a report describing  
97.6 the nature of the information and the commissioner's basis for withholding the information  
97.7 from disclosure.

97.8 (e) To the extent the information required to be posted under this subdivision is collected  
97.9 and made available to the public by another state, by the University of Minnesota, or through  
97.10 an online drug pricing reference and analytical tool, the commissioner may reference the  
97.11 availability of this drug price data from another source including, within existing  
97.12 appropriations, creating the ability of the public to access the data from the source for  
97.13 purposes of meeting the reporting requirements of this subdivision.

97.14 Sec. 11. Minnesota Statutes 2022, section 62J.84, subdivision 7, is amended to read:

97.15 Subd. 7. **Consultation.** (a) The commissioner may consult with a private entity or  
97.16 consortium that satisfies the standards of section 62U.04, subdivision 6, the University of  
97.17 Minnesota, or the commissioner of commerce, as appropriate, in issuing the form and format  
97.18 of the information reported under this section; in posting information pursuant to subdivision  
97.19 6; and in taking any other action for the purpose of implementing this section.

97.20 (b) The commissioner may consult with representatives of the ~~manufacturers~~ reporting  
97.21 entities to establish a standard format for reporting information under this section and may  
97.22 use existing reporting methodologies to establish a standard format to minimize  
97.23 administrative burdens to the state and ~~manufacturers~~ reporting entities.

97.24 Sec. 12. Minnesota Statutes 2022, section 62J.84, subdivision 8, is amended to read:

97.25 Subd. 8. **Enforcement and penalties.** (a) A ~~manufacturer~~ reporting entity may be subject  
97.26 to a civil penalty, as provided in paragraph (b), for:

97.27 (1) failing to register under subdivision 15;

97.28 ~~(1)~~ (2) failing to submit timely reports or notices as required by this section;

97.29 ~~(2)~~ (3) failing to provide information required under this section; or

97.30 ~~(3)~~ (4) providing inaccurate or incomplete information under this section.

98.1 (b) The commissioner shall adopt a schedule of civil penalties, not to exceed \$10,000  
98.2 per day of violation, based on the severity of each violation.

98.3 (c) The commissioner shall impose civil penalties under this section as provided in  
98.4 section 144.99, subdivision 4.

98.5 (d) The commissioner may remit or mitigate civil penalties under this section upon terms  
98.6 and conditions the commissioner considers proper and consistent with public health and  
98.7 safety.

98.8 (e) Civil penalties collected under this section shall be deposited in the health care access  
98.9 fund.

98.10 Sec. 13. Minnesota Statutes 2022, section 62J.84, subdivision 9, is amended to read:

98.11 Subd. 9. **Legislative report.** (a) No later than May 15, 2022, and by January 15 of each  
98.12 year thereafter, the commissioner shall report to the chairs and ranking minority members  
98.13 of the legislative committees with jurisdiction over commerce and health and human services  
98.14 policy and finance on the implementation of this section, including but not limited to the  
98.15 effectiveness in addressing the following goals:

98.16 (1) promoting transparency in pharmaceutical pricing for the state and other payers;

98.17 (2) enhancing the understanding on pharmaceutical spending trends; and

98.18 (3) assisting the state and other payers in the management of pharmaceutical costs.

98.19 (b) The report must include a summary of the information submitted to the commissioner  
98.20 under subdivisions 3, 4, and ~~5~~ 11 to 14.

98.21 Sec. 14. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to  
98.22 read:

98.23 **Subd. 10. Notice of prescription drugs of substantial public interest.** (a) No later than  
98.24 January 31, 2024, and quarterly thereafter, the commissioner shall produce and post on the  
98.25 department's website a list of prescription drugs that the department determines to represent  
98.26 a substantial public interest and for which the department intends to request data under  
98.27 subdivisions 11 to 14, subject to paragraph (c). The department shall base its inclusion of  
98.28 prescription drugs on any information the department determines is relevant to providing  
98.29 greater consumer awareness of the factors contributing to the cost of prescription drugs in  
98.30 the state, and the department shall consider drug product families that include prescription  
98.31 drugs:

99.1 (1) that triggered reporting under subdivision 3 or 4 during the previous calendar quarter;  
99.2 (2) for which average claims paid amounts exceeded 125 percent of the price as of the  
99.3 claim incurred date during the most recent calendar quarter for which claims paid amounts  
99.4 are available; or

99.5 (3) that are identified by members of the public during a public comment period process.

99.6 (b) Not sooner than 30 days after publicly posting the list of prescription drugs under  
99.7 paragraph (a), the department shall notify, via email, reporting entities registered with the  
99.8 department of the requirement to report under subdivisions 11 to 14.

99.9 (c) No more than 500 prescription drugs may be designated as having a substantial public  
99.10 interest in any one notice.

99.11 Sec. 15. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to  
99.12 read:

99.13 Subd. 11. **Manufacturer prescription drug substantial public interest reporting.** (a)  
99.14 Beginning January 1, 2024, a manufacturer must submit to the commissioner the information  
99.15 described in paragraph (b) for any prescription drug:

99.16 (1) included in a notification to report issued to the manufacturer by the department  
99.17 under subdivision 10;

99.18 (2) which the manufacturer manufactures or repackages;

99.19 (3) for which the manufacturer sets the wholesale acquisition cost; and

99.20 (4) for which the manufacturer has not submitted data under subdivision 3 during the  
99.21 120-day period prior to the date of the notification to report.

99.22 (b) For each of the drugs described in paragraph (a), the manufacturer shall submit to  
99.23 the commissioner no later than 60 days after the date of the notification to report, in the  
99.24 form and manner prescribed by the commissioner, the following information, if applicable:

99.25 (1) a description of the drug with the following listed separately:

99.26 (i) the national drug code;

99.27 (ii) the product name;

99.28 (iii) the dosage form;

99.29 (iv) the strength; and

99.30 (v) the package size;

- 100.1 (2) the price of the drug product on the later of:
- 100.2 (i) the day one year prior to the date of the notification to report;
- 100.3 (ii) the introduced to market date; or
- 100.4 (iii) the acquisition date;
- 100.5 (3) the price of the drug product on the date of the notification to report;
- 100.6 (4) the introductory price of the prescription drug when it was introduced for sale in the
- 100.7 United States and the price of the drug on the last day of each of the five calendar years
- 100.8 preceding the date of the notification to report;
- 100.9 (5) the direct costs incurred during the 12-month period prior to the date of the notification
- 100.10 to report by the manufacturers that are associated with the prescription drug, listed separately:
- 100.11 (i) to manufacture the prescription drug;
- 100.12 (ii) to market the prescription drug, including advertising costs; and
- 100.13 (iii) to distribute the prescription drug;
- 100.14 (6) the number of units of the prescription drug sold during the 12-month period prior
- 100.15 to the date of the notification to report;
- 100.16 (7) the total sales revenue for the prescription drug during the 12-month period prior to
- 100.17 the date of the notification to report;
- 100.18 (8) the total rebate payable amount accrued for the prescription drug during the 12-month
- 100.19 period prior to the date of the notification to report;
- 100.20 (9) the manufacturer's net profit attributable to the prescription drug during the 12-month
- 100.21 period prior to the date of the notification to report;
- 100.22 (10) the total amount of financial assistance the manufacturer has provided through
- 100.23 patient prescription assistance programs during the 12-month period prior to the date of the
- 100.24 notification to report, if applicable;
- 100.25 (11) any agreement between a manufacturer and another entity contingent upon any
- 100.26 delay in offering to market a generic version of the prescription drug;
- 100.27 (12) the patent expiration date of the prescription drug if the prescription drug is under
- 100.28 patent;
- 100.29 (13) the name and location of the company that manufactured the drug;

101.1 (14) if the prescription drug is a brand name prescription drug, the ten countries other  
101.2 than the United States that paid the highest prices for the prescription drug during the  
101.3 previous calendar year and their prices; and

101.4 (15) if the prescription drug was acquired by the manufacturer within a 12-month period  
101.5 prior to the date of the notification to report, all of the following information:

101.6 (i) the price at acquisition;

101.7 (ii) the price in the calendar year prior to acquisition;

101.8 (iii) the name of the company from which the drug was acquired;

101.9 (iv) the date of acquisition; and

101.10 (v) the acquisition price.

101.11 (c) The manufacturer may submit any documentation necessary to support the information  
101.12 reported under this subdivision.

101.13 Sec. 16. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to  
101.14 read:

101.15 Subd. 12. **Pharmacy prescription drug substantial public interest reporting.** (a)  
101.16 Beginning January 1, 2024, a pharmacy must submit to the commissioner the information  
101.17 described in paragraph (b) for any prescription drug included in a notification to report  
101.18 issued to the pharmacy by the department under subdivision 10.

101.19 (b) For each of the drugs described in paragraph (a), the pharmacy shall submit to the  
101.20 commissioner no later than 60 days after the date of the notification to report, in the form  
101.21 and manner prescribed by the commissioner, the following information, if applicable:

101.22 (1) a description of the drug with the following listed separately:

101.23 (i) the national drug code;

101.24 (ii) the product name;

101.25 (iii) the dosage form;

101.26 (iv) the strength; and

101.27 (v) the package size;

101.28 (2) the number of units of the drug acquired during the 12-month period prior to the date  
101.29 of the notification to report;

102.1 (3) the total spent before rebates by the pharmacy to acquire the drug during the 12-month  
102.2 period prior to the date of the notification to report;

102.3 (4) the total rebate receivable amount accrued by the pharmacy for the drug during the  
102.4 12-month period prior to the date of the notification to report;

102.5 (5) the number of pricing units of the drug dispensed by the pharmacy during the  
102.6 12-month period prior to the date of the notification to report;

102.7 (6) the total payment receivable by the pharmacy for dispensing the drug including  
102.8 ingredient cost, dispensing fee, and administrative fees during the 12-month period prior  
102.9 to the date of the notification to report;

102.10 (7) the total rebate payable amount accrued by the pharmacy for the drug during the  
102.11 12-month period prior to the date of the notification to report; and

102.12 (8) the average cash price paid by consumers per pricing unit for prescriptions dispensed  
102.13 where no claim was submitted to a health care service plan or health insurer during the  
102.14 12-month period prior to the date of the notification to report.

102.15 (c) The pharmacy may submit any documentation necessary to support the information  
102.16 reported under this subdivision.

102.17 Sec. 17. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to  
102.18 read:

102.19 Subd. 13. **PBM prescription drug substantial public interest reporting.** (a) Beginning  
102.20 January 1, 2024, a PBM must submit to the commissioner the information described in  
102.21 paragraph (b) for any prescription drug included in a notification to report issued to the  
102.22 PBM by the department under subdivision 10.

102.23 (b) For each of the drugs described in paragraph (a), the PBM shall submit to the  
102.24 commissioner no later than 60 days after the date of the notification to report, in the form  
102.25 and manner prescribed by the commissioner, the following information, if applicable:

102.26 (1) a description of the drug with the following listed separately:

102.27 (i) the national drug code;

102.28 (ii) the product name;

102.29 (iii) the dosage form;

102.30 (iv) the strength; and

102.31 (v) the package size;

103.1 (2) the number of pricing units of the drug product filled for which the PBM administered  
103.2 claims during the 12-month period prior to the date of the notification to report;

103.3 (3) the total reimbursement amount accrued and payable to pharmacies for pricing units  
103.4 of the drug product filled for which the PBM administered claims during the 12-month  
103.5 period prior to the date of the notification to report;

103.6 (4) the total reimbursement or administrative fee amount, or both, accrued and receivable  
103.7 from payers for pricing units of the drug product filled for which the PBM administered  
103.8 claims during the 12-month period prior to the date of the notification to report;

103.9 (5) the total rebate receivable amount accrued by the PBM for the drug product during  
103.10 the 12-month period prior to the date of the notification to report; and

103.11 (6) the total rebate payable amount accrued by the PBM for the drug product during the  
103.12 12-month period prior to the date of the notification to report.

103.13 (c) The PBM may submit any documentation necessary to support the information  
103.14 reported under this subdivision.

103.15 Sec. 18. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to  
103.16 read:

103.17 Subd. 14. **Wholesaler prescription drug substantial public interest reporting.** (a)  
103.18 Beginning January 1, 2024, a wholesaler must submit to the commissioner the information  
103.19 described in paragraph (b) for any prescription drug included in a notification to report  
103.20 issued to the wholesaler by the department under subdivision 10.

103.21 (b) For each of the drugs described in paragraph (a), the wholesaler shall submit to the  
103.22 commissioner no later than 60 days after the date of the notification to report, in the form  
103.23 and manner prescribed by the commissioner, the following information, if applicable:

103.24 (1) a description of the drug with the following listed separately:

103.25 (i) the national drug code;

103.26 (ii) the product name;

103.27 (iii) the dosage form;

103.28 (iv) the strength; and

103.29 (v) the package size;

103.30 (2) the number of units of the drug product acquired by the wholesale drug distributor  
103.31 during the 12-month period prior to the date of the notification to report;

104.1 (3) the total spent before rebates by the wholesale drug distributor to acquire the drug  
104.2 product during the 12-month period prior to the date of the notification to report;

104.3 (4) the total rebate receivable amount accrued by the wholesale drug distributor for the  
104.4 drug product during the 12-month period prior to the date of the notification to report;

104.5 (5) the number of units of the drug product sold by the wholesale drug distributor during  
104.6 the 12-month period prior to the date of the notification to report;

104.7 (6) gross revenue from sales in the United States generated by the wholesale drug  
104.8 distributor for this drug product during the 12-month period prior to the date of the  
104.9 notification to report; and

104.10 (7) total rebate payable amount accrued by the wholesale drug distributor for the drug  
104.11 product during the 12-month period prior to the date of the notification to report.

104.12 (c) The wholesaler may submit any documentation necessary to support the information  
104.13 reported under this subdivision.

104.14 Sec. 19. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to  
104.15 read:

104.16 Subd. 15. **Registration requirements.** Beginning January 1, 2024, a reporting entity  
104.17 subject to this chapter shall register with the department in a form and manner prescribed  
104.18 by the commissioner.

104.19 Sec. 20. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to  
104.20 read:

104.21 Subd. 16. **Rulemaking.** For the purposes of this section, the commissioner may use the  
104.22 expedited rulemaking process under section 14.389.

104.23 Sec. 21. Minnesota Statutes 2022, section 62Q.01, is amended by adding a subdivision to  
104.24 read:

104.25 Subd. 6b. **No Surprises Act.** "No Surprises Act" means Division BB of the Consolidated  
104.26 Appropriations Act, 2021, which amended Title XXVII of the Public Health Service Act,  
104.27 Public Law 116-260, and any amendments to and any federal guidance or regulations issued  
104.28 under this act.

105.1 Sec. 22. Minnesota Statutes 2022, section 62Q.021, is amended by adding a subdivision  
105.2 to read:

105.3 Subd. 3. **Compliance with 2021 federal law.** Each health plan company, health provider,  
105.4 and health facility shall comply with the No Surprises Act, including any federal regulations  
105.5 adopted under the act, to the extent that the act imposes requirements that apply in this state  
105.6 but are not required under the laws of this state. This subdivision does not require compliance  
105.7 with any provision of the No Surprises Act before the effective date provided for that  
105.8 provision in the No Surprises Act. The commissioner shall enforce this subdivision.

105.9 Sec. 23. Minnesota Statutes 2022, section 62Q.55, subdivision 5, is amended to read:

105.10 Subd. 5. **Coverage restrictions or limitations.** If emergency services are provided by  
105.11 a nonparticipating provider, with or without prior authorization, the health plan company  
105.12 shall not impose coverage restrictions or limitations that are more restrictive than apply to  
105.13 emergency services received from a participating provider. Cost-sharing requirements that  
105.14 apply to emergency services received out-of-network must be the same as the cost-sharing  
105.15 requirements that apply to services received in-network and shall count toward the in-network  
105.16 deductible. All coverage and charges for emergency services must comply with the No  
105.17 Surprises Act.

105.18 Sec. 24. Minnesota Statutes 2022, section 62Q.556, is amended to read:

105.19 **62Q.556 UNAUTHORIZED PROVIDER SERVICES CONSUMER**  
105.20 **PROTECTIONS AGAINST BALANCE BILLING.**

105.21 Subdivision 1. ~~Unauthorized provider services~~ **Nonparticipating provider balance**  
105.22 **billing prohibition.** (a) Except as provided in paragraph (e), ~~unauthorized provider services~~  
105.23 ~~or~~ (b), balance billing is prohibited when an enrollee receives services from:

105.24 (1) ~~from~~ a nonparticipating provider at a participating hospital or ambulatory surgical  
105.25 center, ~~when the services are rendered:~~ as described by the No Surprises Act, including any  
105.26 federal regulations adopted under that act;

105.27 ~~(i) due to the unavailability of a participating provider;~~

105.28 ~~(ii) by a nonparticipating provider without the enrollee's knowledge; or~~

105.29 ~~(iii) due to the need for unforeseen services arising at the time the services are being~~  
105.30 ~~rendered; or~~

106.1 (2) ~~from~~ a participating provider that sends a specimen taken from the enrollee in the  
 106.2 participating provider's practice setting to a nonparticipating laboratory, pathologist, or other  
 106.3 medical testing facility; or

106.4 (3) a nonparticipating provider or facility providing emergency services as defined in  
 106.5 section 62Q.55, subdivision 3, and other services as described in the requirements of the  
 106.6 No Surprises Act.

106.7 ~~(b) Unauthorized provider services do not include emergency services as defined in~~  
 106.8 ~~section 62Q.55, subdivision 3.~~

106.9 ~~(e)~~ (b) The services described in paragraph (a), ~~clause (2)~~ clauses (1), (2), and (3), as  
 106.10 defined in the No Surprises Act, and any federal regulations adopted under that act, are not  
 106.11 ~~unauthorized provider services~~ subject to balance billing if the enrollee gives advance written  
 106.12 provides informed consent to prior to receiving services from the nonparticipating provider  
 106.13 acknowledging that the use of a provider, or the services to be rendered, may result in costs  
 106.14 not covered by the health plan. The informed consent must comply with all requirements  
 106.15 of the No Surprises Act, including any federal regulations adopted under that act.

106.16 Subd. 2. **Prohibition Cost-sharing requirements and independent dispute**  
 106.17 **resolution.** (a) An enrollee's financial responsibility for the ~~unauthorized~~ nonparticipating  
 106.18 provider services described in subdivision 1, paragraph (a), shall be the same cost-sharing  
 106.19 requirements, including co-payments, deductibles, coinsurance, coverage restrictions, and  
 106.20 coverage limitations, as those applicable to services received by the enrollee from a  
 106.21 participating provider. A health plan company must apply any enrollee cost sharing  
 106.22 requirements, including co-payments, deductibles, and coinsurance, for unauthorized  
 106.23 nonparticipating provider services to the enrollee's annual out-of-pocket limit to the same  
 106.24 extent payments to a participating provider would be applied.

106.25 (b) A health plan company must attempt to negotiate the reimbursement, less any  
 106.26 applicable enrollee cost sharing under paragraph (a), for the ~~unauthorized~~ nonparticipating  
 106.27 provider services with the nonparticipating provider. If a health plan company's and  
 106.28 ~~nonparticipating provider's attempts~~ the attempt to negotiate reimbursement for the health  
 106.29 ~~care~~ nonparticipating provider services ~~do~~ does not result in a resolution, ~~the health plan~~  
 106.30 ~~company or provider may elect to refer the matter for binding arbitration, chosen in~~  
 106.31 ~~accordance with paragraph (c). A nondisclosure agreement must be executed by both parties~~  
 106.32 ~~prior to engaging an arbitrator in accordance with this section. The cost of arbitration must~~  
 106.33 ~~be shared equally between the parties.~~ either party may initiate the federal independent

107.1 dispute resolution process pursuant to the No Surprises Act, including any federal regulations  
107.2 adopted under that act.

107.3 ~~(c) The commissioner of health, in consultation with the commissioner of the Bureau~~  
107.4 ~~of Mediation Services, must develop a list of professionals qualified in arbitration, for the~~  
107.5 ~~purpose of resolving disputes between a health plan company and nonparticipating provider~~  
107.6 ~~arising from the payment for unauthorized provider services. The commissioner of health~~  
107.7 ~~shall publish the list on the Department of Health website, and update the list as appropriate.~~

107.8 ~~(d) The arbitrator must consider relevant information, including the health plan company's~~  
107.9 ~~payments to other nonparticipating providers for the same services, the circumstances and~~  
107.10 ~~complexity of the particular case, and the usual and customary rate for the service based on~~  
107.11 ~~information available in a database in a national, independent, not-for-profit corporation,~~  
107.12 ~~and similar fees received by the provider for the same services from other health plans in~~  
107.13 ~~which the provider is nonparticipating, in reaching a decision.~~

107.14 Subd. 3. Annual data reporting. (a) Beginning April 1, 2024, a health plan company  
107.15 must report annually to the commissioner of health:

107.16 (1) the total number of claims and total billed and paid amounts for nonparticipating  
107.17 provider services, by service and provider type, submitted to the health plan in the prior  
107.18 calendar year; and

107.19 (2) the total number of enrollee complaints received regarding the rights and protections  
107.20 established by the No Surprises Act in the prior calendar year.

107.21 (b) The commissioners of commerce and health shall develop the form and manner for  
107.22 health plan companies to comply with paragraph (a).

107.23 Subd. 4. Enforcement. (a) Any provider or facility, including a health care provider or  
107.24 facility pursuant to section 62A.63, subdivision 2, or 62J.03, subdivision 8, that is subject  
107.25 to the relevant provisions of the No Surprises Act is subject to the requirements of this  
107.26 section and section 62J.811.

107.27 (b) The commissioner of commerce or health shall enforce this section.

107.28 (c) If a health-related licensing board has cause to believe that a provider has violated  
107.29 this section, it may further investigate and enforce the provisions of this section pursuant  
107.30 to chapter 214.

108.1 Sec. 25. Minnesota Statutes 2022, section 62Q.56, subdivision 2, is amended to read:

108.2 Subd. 2. **Change in health plans.** (a) If an enrollee is subject to a change in health plans,  
108.3 the enrollee's new health plan company must provide, upon request, authorization to receive  
108.4 services that are otherwise covered under the terms of the new health plan through the  
108.5 enrollee's current provider:

108.6 (1) for up to 120 days if the enrollee is engaged in a current course of treatment for one  
108.7 or more of the following conditions:

108.8 (i) an acute condition;

108.9 (ii) a life-threatening mental or physical illness;

108.10 (iii) pregnancy ~~beyond the first trimester of pregnancy;~~

108.11 (iv) a physical or mental disability defined as an inability to engage in one or more major  
108.12 life activities, provided that the disability has lasted or can be expected to last for at least  
108.13 one year, or can be expected to result in death; or

108.14 (v) a disabling or chronic condition that is in an acute phase; or

108.15 (2) for the rest of the enrollee's life if a physician certifies that the enrollee has an expected  
108.16 lifetime of 180 days or less.

108.17 For all requests for authorization under this paragraph, the health plan company must grant  
108.18 the request for authorization unless the enrollee does not meet the criteria provided in this  
108.19 paragraph.

108.20 (b) The health plan company shall prepare a written plan that provides a process for  
108.21 coverage determinations regarding continuity of care of up to 120 days for new enrollees  
108.22 who request continuity of care with their former provider, if the new enrollee:

108.23 (1) is receiving culturally appropriate services and the health plan company does not  
108.24 have a provider in its preferred provider network with special expertise in the delivery of  
108.25 those culturally appropriate services within the time and distance requirements of section  
108.26 62D.124, subdivision 1; or

108.27 (2) does not speak English and the health plan company does not have a provider in its  
108.28 preferred provider network who can communicate with the enrollee, either directly or through  
108.29 an interpreter, within the time and distance requirements of section 62D.124, subdivision  
108.30 1.

108.31 The written plan must explain the criteria that will be used to determine whether a need for  
108.32 continuity of care exists and how it will be provided.

109.1 (c) This subdivision applies only to group coverage and continuation and conversion  
109.2 coverage, and applies only to changes in health plans made by the employer.

109.3 Sec. 26. Minnesota Statutes 2022, section 62Q.73, subdivision 1, is amended to read:

109.4 Subdivision 1. **Definition.** For purposes of this section, "adverse determination" means:

109.5 (1) for individual health plans, a complaint decision relating to a health care service or  
109.6 claim that is partially or wholly adverse to the complainant;

109.7 (2) an individual health plan that is grandfathered plan coverage may instead apply the  
109.8 definition of adverse determination for group coverage in clause (3);

109.9 (3) for group health plans, a complaint decision relating to a health care service or claim  
109.10 that has been appealed in accordance with section 62Q.70 and the appeal decision is partially  
109.11 or wholly adverse to the complainant;

109.12 (4) any adverse determination, as defined in section 62M.02, subdivision 1a, that has  
109.13 been appealed in accordance with section 62M.06 and the appeal did not reverse the adverse  
109.14 determination;

109.15 (5) a decision relating to a health care service made by a health plan company licensed  
109.16 under chapter 60A that denies the service on the basis that the service was not medically  
109.17 necessary; ~~or~~

109.18 (6) the enrollee has met the requirements of subdivision 6, paragraph (e); or

109.19 (7) a decision relating to a health plan's coverage of nonparticipating provider services  
109.20 as described in and subject to section 62Q.556, subdivision 1, paragraph (a).

109.21 An adverse determination does not include complaints relating to fraudulent marketing  
109.22 practices or agent misrepresentation.

109.23 Sec. 27. Minnesota Statutes 2022, section 62Q.73, subdivision 7, is amended to read:

109.24 Subd. 7. **Standards of review.** (a) For an external review of any issue in an adverse  
109.25 determination that does not require a medical necessity determination, the external review  
109.26 must be based on whether the adverse determination was in compliance with the enrollee's  
109.27 health benefit plan or section 62Q.556, subdivision 1, paragraph (a).

109.28 (b) For an external review of any issue in an adverse determination by a health plan  
109.29 company licensed under chapter 62D that requires a medical necessity determination, the  
109.30 external review must determine whether the adverse determination was consistent with the  
109.31 definition of medically necessary care in Minnesota Rules, part 4685.0100, subpart 9b.

110.1 (c) For an external review of any issue in an adverse determination by a health plan  
110.2 company, other than a health plan company licensed under chapter 62D, that requires a  
110.3 medical necessity determination, the external review must determine whether the adverse  
110.4 determination was consistent with the definition of medically necessary care in section  
110.5 62Q.53, subdivision 2.

110.6 (d) For an external review of an adverse determination involving experimental or  
110.7 investigational treatment, the external review entity must base its decision on all documents  
110.8 submitted by the health plan company and enrollee, including:

110.9 (1) medical records;

110.10 (2) the recommendation of the attending physician, advanced practice registered nurse,  
110.11 physician assistant, or health care professional;

110.12 (3) consulting reports from health care professionals;

110.13 (4) the terms of coverage;

110.14 (5) federal Food and Drug Administration approval; and

110.15 (6) medical or scientific evidence or evidence-based standards.

110.16 Sec. 28. Minnesota Statutes 2022, section 62U.04, subdivision 4, is amended to read:

110.17 Subd. 4. **Encounter data.** (a) All health plan companies, dental plan companies, and  
110.18 third-party administrators shall submit encounter data on a monthly basis to a private entity  
110.19 designated by the commissioner of health. The data shall be submitted in a form and manner  
110.20 specified by the commissioner subject to the following requirements:

110.21 (1) the data must be de-identified data as described under the Code of Federal Regulations,  
110.22 title 45, section 164.514;

110.23 (2) the data for each encounter must include an identifier for the patient's health care  
110.24 home if the patient has selected a health care home, data on contractual value-based payments,  
110.25 ~~and, for claims incurred on or after January 1, 2019,~~ data deemed necessary by the  
110.26 commissioner to uniquely identify claims in the individual health insurance market; ~~and~~

110.27 (3) the data must include enrollee race and ethnicity, to the extent available; and

110.28 ~~(3)~~ (4) except for the identifier data described in clause clauses (2) and (3), the data must  
110.29 not include information that is not included in a health care claim, dental care claim, or  
110.30 equivalent encounter information transaction that is required under section 62J.536.

111.1 (b) The commissioner or the commissioner's designee shall only use the data submitted  
111.2 under paragraph (a) to carry out the commissioner's responsibilities in this section, including  
111.3 supplying the data to providers so they can verify their results of the peer grouping process  
111.4 consistent with the recommendations developed pursuant to subdivision 3c, paragraph (d),  
111.5 and adopted by the commissioner and, if necessary, submit comments to the commissioner  
111.6 or initiate an appeal.

111.7 (c) Data on providers collected under this subdivision are private data on individuals or  
111.8 nonpublic data, as defined in section 13.02. ~~Notwithstanding the definition of summary data~~  
111.9 ~~in section 13.02, subdivision 19, summary data prepared under this subdivision may be~~  
111.10 ~~derived from nonpublic data.~~ Notwithstanding the data classifications in this paragraph,  
111.11 data on providers collected under this subdivision may be released or published as authorized  
111.12 in subdivision 11. The commissioner or the commissioner's designee shall establish  
111.13 procedures and safeguards to protect the integrity and confidentiality of any data that it  
111.14 maintains.

111.15 (d) The commissioner or the commissioner's designee shall not publish analyses or  
111.16 reports that identify, or could potentially identify, individual patients.

111.17 (e) The commissioner shall compile summary information on the data submitted under  
111.18 this subdivision. The commissioner shall work with its vendors to assess the data submitted  
111.19 in terms of compliance with the data submission requirements and the completeness of the  
111.20 data submitted by comparing the data with summary information compiled by the  
111.21 commissioner and with established and emerging data quality standards to ensure data  
111.22 quality.

111.23 **EFFECTIVE DATE.** Paragraph (a), clause (3), is effective retroactively from January  
111.24 1, 2023, and applies to claims incurred on or after that date.

111.25 Sec. 29. Minnesota Statutes 2022, section 62U.04, subdivision 5, is amended to read:

111.26 Subd. 5. **Pricing data.** (a) All health plan companies, dental plan companies, and  
111.27 third-party administrators shall submit, on a monthly basis, data on their contracted prices  
111.28 with health care providers and dental care providers to a private entity designated by the  
111.29 commissioner of health for the purposes of performing the analyses required under this  
111.30 subdivision. Data on contracted prices submitted under this paragraph must include data on  
111.31 supplemental contractual value-based payments paid to health care providers. The data shall  
111.32 be submitted in the form and manner specified by the commissioner of health.

112.1 (b) The commissioner or the commissioner's designee shall only use the data submitted  
112.2 under this subdivision to carry out the commissioner's responsibilities under this section,  
112.3 including supplying the data to providers so they can verify their results of the peer grouping  
112.4 process consistent with the recommendations developed pursuant to subdivision 3c, paragraph  
112.5 (d), and adopted by the commissioner and, if necessary, submit comments to the  
112.6 commissioner or initiate an appeal.

112.7 (c) Data collected under this subdivision are nonpublic data as defined in section 13.02.  
112.8 Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary  
112.9 data prepared under this section may be derived from nonpublic data. Notwithstanding the  
112.10 data classifications in this paragraph, data on providers collected under this subdivision  
112.11 may be released or published as authorized in subdivision 11. The commissioner shall  
112.12 establish procedures and safeguards to protect the integrity and confidentiality of any data  
112.13 that it maintains.

112.14 Sec. 30. Minnesota Statutes 2022, section 62U.04, subdivision 5a, is amended to read:

112.15 Subd. 5a. **Self-insurers.** (a) The commissioner shall not require a self-insurer governed  
112.16 by the federal Employee Retirement Income Security Act of 1974 (ERISA) to comply with  
112.17 this section.

112.18 (b) A third-party administrator must annually notify the self-insurers whose health plans  
112.19 are administered by the third-party administrator that the self-insurer may elect to have the  
112.20 third-party administrator submit encounter data and data on contracted prices under  
112.21 subdivisions 4 and 5 from the self-insurer's health plan for the upcoming plan year. This  
112.22 notice must be provided in a form and manner specified by the commissioner. After receiving  
112.23 responses from self-insurers, a third-party administrator must, in a form and manner specified  
112.24 by the commissioner, report to the commissioner:

112.25 (1) the self-insurers that elected to have the third-party administrator submit encounter  
112.26 data and data on contracted prices from the self-insurer's health plan for the upcoming plan  
112.27 year;

112.28 (2) the self-insurers that declined to have the third-party administrator submit encounter  
112.29 data and data on contracted prices from the self-insurer's health plan for the upcoming plan  
112.30 year; and

112.31 (3) data deemed necessary by the commissioner to identify and track the status of  
112.32 reporting of data from self-insured health plans.

113.1 Sec. 31. Minnesota Statutes 2022, section 62U.04, is amended by adding a subdivision to  
113.2 read:

113.3 Subd. 5b. **Nonclaims-based payments.** (a) Beginning January 1, 2025, all health plan  
113.4 companies and third-party administrators shall submit to a private entity designated by the  
113.5 commissioner of health all nonclaims-based payments made to health care providers. The  
113.6 data shall be submitted in a form, manner, and frequency specified by the commissioner.  
113.7 Nonclaims-based payments are payments to health care providers designed to pay for value  
113.8 of health care services over volume of health care services and include alternative payment  
113.9 models or incentives, payments for infrastructure expenditures or investments, and payments  
113.10 for workforce expenditures or investments. Nonclaims-based payments submitted under  
113.11 this subdivision must, to the extent possible, be attributed to a health care provider in the  
113.12 same manner in which claims-based data are attributed to a health care provider and, where  
113.13 appropriate, must be combined with data collected under subdivisions 4 and 5 in analyses  
113.14 of health care spending.

113.15 (b) Data collected under this subdivision are nonpublic data as defined in section 13.02.  
113.16 Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary  
113.17 data prepared under this subdivision may be derived from nonpublic data. The commissioner  
113.18 shall establish procedures and safeguards to protect the integrity and confidentiality of any  
113.19 data maintained by the commissioner.

113.20 (c) The commissioner shall consult with health plan companies, hospitals, health care  
113.21 providers, and the commissioner of human services in developing the data reported under  
113.22 this subdivision and standardized reporting forms.

113.23 Sec. 32. Minnesota Statutes 2022, section 62U.04, subdivision 11, is amended to read:

113.24 **Subd. 11. Restricted uses of the all-payer claims data.** (a) Notwithstanding subdivision  
113.25 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the commissioner's  
113.26 designee shall only use the data submitted under subdivisions 4 ~~and~~ 5, 5a, and 5b for the  
113.27 ~~following~~ purposes authorized in this subdivision and in subdivision 13:

113.28 (1) to evaluate the performance of the health care home program as authorized under  
113.29 section 62U.03, subdivision 7;

113.30 (2) to study, in collaboration with the reducing avoidable readmissions effectively  
113.31 (RARE) campaign, hospital readmission trends and rates;

113.32 (3) to analyze variations in health care costs, quality, utilization, and illness burden based  
113.33 on geographical areas or populations;

114.1 (4) to evaluate the state innovation model (SIM) testing grant received by the Departments  
114.2 of Health and Human Services, including the analysis of health care cost, quality, and  
114.3 utilization baseline and trend information for targeted populations and communities; ~~and~~

114.4 (5) to compile one or more public use files of summary data or tables that must:

114.5 (i) be available to the public for no or minimal cost by March 1, 2016, and available by  
114.6 web-based electronic data download by June 30, 2019;

114.7 (ii) not identify individual patients, ~~payers, or providers~~ but that may identify the  
114.8 rendering or billing hospital, clinic, or medical practice so long as no individual health  
114.9 professionals are identified and the commissioner finds the data to be accurate, valid, and  
114.10 suitable for publication for such use;

114.11 (iii) be updated by the commissioner, at least annually, with the most current data  
114.12 available; and

114.13 (iv) contain clear and conspicuous explanations of the characteristics of the data, such  
114.14 as the dates of the data contained in the files, the absence of costs of care for uninsured  
114.15 patients or nonresidents, and other disclaimers that provide appropriate context; and

114.16 ~~(v) not lead to the collection of additional data elements beyond what is authorized under~~  
114.17 ~~this section as of June 30, 2015.~~

114.18 (6) to conduct analyses of the impact of health care transactions on health care costs,  
114.19 market consolidation, and quality under section 144.593, subdivision 6.

114.20 (b) The commissioner may publish the results of the authorized uses identified in  
114.21 paragraph (a) ~~so long as the data released publicly do not contain information or descriptions~~  
114.22 ~~in which the identity of individual hospitals, clinics, or other providers may be discerned.~~  
114.23 The data published under this paragraph may identify hospitals, clinics, and medical practices  
114.24 so long as no individual health professionals are identified and the commissioner finds the  
114.25 data to be accurate, valid, and suitable for publication for such use.

114.26 ~~(c) Nothing in this subdivision shall be construed to prohibit the commissioner from~~  
114.27 ~~using the data collected under subdivision 4 to complete the state-based risk adjustment~~  
114.28 ~~system assessment due to the legislature on October 1, 2015.~~

114.29 ~~(d) The commissioner or the commissioner's designee may use the data submitted under~~  
114.30 ~~subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until July 1,~~  
114.31 ~~2023.~~

115.1 ~~(e) The commissioner shall consult with the all-payer claims database work group~~  
115.2 ~~established under subdivision 12 regarding the technical considerations necessary to create~~  
115.3 ~~the public use files of summary data described in paragraph (a), clause (5).~~

115.4 Sec. 33. Minnesota Statutes 2022, section 62U.04, is amended by adding a subdivision to  
115.5 read:

115.6 Subd. 13. **Expanded access to and use of the all-payer claims data.** (a) The  
115.7 commissioner or the commissioner's designee shall make the data submitted under  
115.8 subdivisions 4, 5, 5a, and 5b available to individuals and organizations engaged in research  
115.9 on, or efforts to effect transformation in, health care outcomes, access, quality, disparities,  
115.10 or spending, provided the use of the data serves a public benefit. Data made available under  
115.11 this subdivision may not be used to:

115.12 (1) create an unfair market advantage for any participant in the health care market in  
115.13 Minnesota, including health plan companies, payers, and providers;

115.14 (2) reidentify or attempt to reidentify an individual in the data; or

115.15 (3) publicly report contract details between a health plan company and provider and  
115.16 derived from the data.

115.17 (b) To implement paragraph (a), the commissioner shall:

115.18 (1) establish detailed requirements for data access; a process for data users to apply to  
115.19 access and use the data; legally enforceable data use agreements to which data users must  
115.20 consent; a clear and robust oversight process for data access and use, including a data  
115.21 management plan, that ensures compliance with state and federal data privacy laws;  
115.22 agreements for state agencies and the University of Minnesota to ensure proper and efficient  
115.23 use and security of data; and technical assistance for users of the data and for stakeholders;

115.24 (2) develop a fee schedule to support the cost of expanded access to and use of the data,  
115.25 provided the fees charged under the schedule do not create a barrier to access or use for  
115.26 those most affected by disparities; and

115.27 (3) create a research advisory group to advise the commissioner on applications for data  
115.28 use under this subdivision, including an examination of the rigor of the research approach,  
115.29 the technical capabilities of the proposed user, and the ability of the proposed user to  
115.30 successfully safeguard the data.

116.1 Sec. 34. [115.7411] ADVISORY COUNCIL ON WATER SUPPLY SYSTEMS AND  
116.2 WASTEWATER TREATMENT FACILITIES.

116.3 Subdivision 1. Purpose; membership. The Advisory Council on Water Supply Systems  
116.4 and Wastewater Treatment Facilities shall advise the commissioners of health and the  
116.5 Pollution Control Agency regarding classification of water supply systems and wastewater  
116.6 treatment facilities, qualifications and competency evaluation of water supply system  
116.7 operators and wastewater treatment facility operators, and additional laws, rules, and  
116.8 procedures that may be desirable for regulating the operation of water supply systems and  
116.9 of wastewater treatment facilities. The advisory council is composed of 11 voting members,  
116.10 of whom:

116.11 (1) one member must be from the Department of Health, Division of Environmental  
116.12 Health, appointed by the commissioner of health;

116.13 (2) one member must be from the Pollution Control Agency appointed by the  
116.14 commissioner of the Pollution Control Agency;

116.15 (3) three members must be certified water supply system operators, appointed by the  
116.16 commissioner of health, one of whom must represent a nonmunicipal community or  
116.17 nontransient noncommunity water supply system;

116.18 (4) three members must be certified wastewater treatment facility operators, appointed  
116.19 by the commissioner of the Pollution Control Agency;

116.20 (5) one member must be a representative from an organization representing municipalities,  
116.21 appointed by the commissioner of health with the concurrence of the commissioner of the  
116.22 Pollution Control Agency; and

116.23 (6) two members must be members of the public who are not associated with water  
116.24 supply systems or wastewater treatment facilities. One must be appointed by the  
116.25 commissioner of health and the other by the commissioner of the Pollution Control Agency.  
116.26 Consideration should be given to one of these members being a representative of academia  
116.27 knowledgeable in water or wastewater matters.

116.28 Subd. 2. Geographic representation. At least one of the water supply system operators  
116.29 and at least one of the wastewater treatment facility operators must be from outside the  
116.30 seven-county metropolitan area and one wastewater treatment facility operator must be  
116.31 from the Metropolitan Council.

116.32 Subd. 3. Terms; compensation. The terms of the appointed members and the  
116.33 compensation and removal of all members are governed by section 15.059.

117.1 Subd. 4. **Officers.** When new members are appointed to the council, a chair must be  
117.2 elected at the next council meeting. The Department of Health representative shall serve as  
117.3 secretary of the council.

117.4 Sec. 35. Minnesota Statutes 2022, section 121A.335, subdivision 3, is amended to read:

117.5 Subd. 3. **Frequency of testing.** (a) The plan under subdivision 2 must include a testing  
117.6 schedule for every building serving prekindergarten through grade 12 students. The schedule  
117.7 must require that each building be tested at least once every five years. A school district or  
117.8 charter school must begin testing school buildings by July 1, 2018, and complete testing of  
117.9 all buildings that serve students within five years.

117.10 ~~(b) A school district or charter school that finds lead at a specific location providing~~  
117.11 ~~cooking or drinking water within a facility must formulate, make publicly available, and~~  
117.12 ~~implement a plan that is consistent with established guidelines and recommendations to~~  
117.13 ~~ensure that student exposure to lead is minimized. This includes, when a school district or~~  
117.14 ~~charter school finds the presence of lead at a level where action should be taken as set by~~  
117.15 ~~the guidance in any water source that can provide cooking or drinking water, immediately~~  
117.16 ~~shutting off the water source or making it unavailable until the hazard has been minimized.~~

117.17 Sec. 36. Minnesota Statutes 2022, section 121A.335, subdivision 5, is amended to read:

117.18 Subd. 5. **Reporting.** (a) A school district or charter school that has tested its buildings  
117.19 for the presence of lead shall make the results of the testing available to the public for review  
117.20 and must directly notify parents annually of the availability of the information. School  
117.21 districts and charter schools must follow the actions outlined in guidance from the  
117.22 commissioners of health and education. ~~If a test conducted under subdivision 3, paragraph~~  
117.23 ~~(a), reveals the presence of lead above a level where action should be taken as set by the~~  
117.24 ~~guidance, the school district or charter school must, within 30 days of receiving the test~~  
117.25 ~~result, either remediate the presence of lead to below the level set in guidance, verified by~~  
117.26 ~~retest, or directly notify parents of the test result. The school district or charter school must~~  
117.27 ~~make the water source unavailable until the hazard has been minimized.~~

117.28 (b) Results of testing, and any planned remediation steps, shall be made available within  
117.29 30 days of receiving results.

117.30 (c) A school district or charter school that has tested for lead in drinking water shall  
117.31 report the results of testing and any planned remediation steps to the school board at the  
117.32 next available school board meeting or within 30 days of receiving results, whichever is  
117.33 sooner.

118.1 (d) The school district or charter school shall maintain lead testing in drinking water  
118.2 records electronically or by paper copy for at least 15 years.

118.3 (e) Beginning July 1, 2024, school districts and charter schools must report their test  
118.4 results and remediation activities to the commissioner of health on or before July 1 of each  
118.5 year.

118.6 Sec. 37. Minnesota Statutes 2022, section 121A.335, is amended by adding a subdivision  
118.7 to read:

118.8 Subd. 6. Remediation. (a) A school district or charter school that finds lead above five  
118.9 parts per billion at a specific location providing cooking or drinking water within a facility  
118.10 must formulate, make publicly available, and implement a plan to remediate the lead in  
118.11 drinking water. The plan must be consistent with established guidelines and recommendations  
118.12 to ensure exposure to lead is remediated.

118.13 (b) When lead is found above five parts per billion the water fixture shall immediately  
118.14 be shut off or made unavailable for consumption until the hazard has been minimized as  
118.15 verified by a test.

118.16 (c) If the school district or charter school receives water from a public water supply that  
118.17 has an action level in exceedance of the federal Lead and Copper Rule, it may delay  
118.18 remediation activities until the public water system meets state and federal requirements in  
118.19 the Lead and Copper Rule. If the school district or charter school receives water from a lead  
118.20 service line or other lead infrastructure owned by the public water supply, the school district  
118.21 may delay remediation of fixtures until the lead service line is fully replaced. The school  
118.22 must ensure that any fixture testing above five parts per billion is not used for consumption  
118.23 until remediation activities are complete.

118.24 Sec. 38. [144.0526] MINNESOTA ONE HEALTH ANTIMICROBIAL  
118.25 STEWARDSHIP COLLABORATIVE.

118.26 Subdivision 1. Establishment. The commissioner of health shall establish the Minnesota  
118.27 One Health Antimicrobial Stewardship Collaborative. The commissioner shall appoint a  
118.28 director to execute operations, conduct health education, and provide technical assistance.

118.29 Subd. 2. Commissioner's duties. The commissioner of health shall oversee a program  
118.30 to:

118.31 (1) maintain the position of director of One Health Antimicrobial Stewardship to lead  
118.32 state antimicrobial stewardship initiatives across human, animal, and environmental health;

119.1 (2) communicate to professionals and the public the interconnectedness of human, animal,  
119.2 and environmental health, especially related to preserving the efficacy of antibiotic  
119.3 medications, which are a shared resource;

119.4 (3) leverage new and existing partnerships. The commissioner of health shall consult  
119.5 and collaborate with organizations and agencies in fields including but not limited to health  
119.6 care, veterinary medicine, animal agriculture, academic institutions, and industry and  
119.7 community organizations to inform strategies for education, practice improvement, and  
119.8 research in all settings where antimicrobial products are used;

119.9 (4) ensure that veterinary settings have education and strategies needed to practice  
119.10 appropriate antibiotic prescribing, implement clinical antimicrobial stewardship programs,  
119.11 and prevent transmission of antimicrobial-resistant microbes; and

119.12 (5) support collaborative research and programmatic initiatives to improve the  
119.13 understanding of the impact of antimicrobial use and resistance in the natural environment.

119.14 Sec. 39. **[144.0528] COMPREHENSIVE DRUG OVERDOSE AND MORBIDITY**  
119.15 **PREVENTION ACT.**

119.16 Subdivision 1. **Definition.** For the purpose of this section, "drug overdose and morbidity"  
119.17 means health problems that people experience after inhaling, ingesting, or injecting medicines  
119.18 in quantities that exceed prescription status; medicines taken that are prescribed to a different  
119.19 person; medicines that have been adulterated or adjusted by contaminants intentionally or  
119.20 unintentionally; or nonprescription drugs in amounts that result in morbidity or mortality.

119.21 Subd. 2. **Establishment.** (a) The commissioner of health shall establish a comprehensive  
119.22 drug overdose and morbidity program to conduct comprehensive drug overdose and morbidity  
119.23 prevention activities, epidemiologic investigations and surveillance, and evaluation to  
119.24 monitor, address, and prevent drug overdoses statewide through integrated strategies that  
119.25 include the following:

119.26 (1) advance access to evidence-based nonnarcotic pain management services;

119.27 (2) implement culturally specific interventions and prevention programs with population  
119.28 and community groups in greatest need, including those who are pregnant and their infants;

119.29 (3) enhance overdose prevention and supportive services for people experiencing  
119.30 homelessness. This strategy includes funding for emergency and short-term housing subsidies  
119.31 through the homeless overdose prevention hub and expanding support for syringe services  
119.32 programs serving people experiencing homelessness statewide;

120.1 (4) equip employers to promote health and well-being of employees by addressing  
120.2 substance misuse and drug overdose;

120.3 (5) improve outbreak detection and identification of substances involved in overdoses  
120.4 through the expansion of the Minnesota Drug Overdose and Substance Use Surveillance  
120.5 Activity (MNDOSA);

120.6 (6) implement Tackling Overdose With Networks (TOWN) community prevention  
120.7 programs;

120.8 (7) identify, address, and respond to drug overdose and morbidity in those who are  
120.9 pregnant or have just given birth through multitiered approaches that may:

120.10 (i) promote medication-assisted treatment options;

120.11 (ii) support programs that provide services in accord with evidence-based care models  
120.12 for mental health and substance abuse disorder;

120.13 (iii) collaborate with interdisciplinary and professional organizations that focus on quality  
120.14 improvement initiatives related to substance use disorder; and

120.15 (iv) implement substance use disorder-related recommendations from the maternal  
120.16 mortality review committee, as appropriate; and

120.17 (8) design a system to assess, address, and prevent the impacts of drug overdose and  
120.18 morbidity on those who are pregnant, their infants, and children. Specifically, the  
120.19 commissioner of health may:

120.20 (i) systematically collect data to identify, analyze, and interpret the impact, incidence,  
120.21 incidence trends, conditions, treatments, and health, educational, and developmental outcomes  
120.22 associated with prenatal exposure to harmful substances through maternal substance use;

120.23 (ii) collect data, including on diagnosis, management, interventions, and outcomes, from  
120.24 relevant sources identified by the commissioner, including hospitals, clinics, laboratory  
120.25 settings, and other entities and providers involved in the care or treatment of infants, children,  
120.26 and those who are pregnant. This data may be collected in collaboration with other prenatal,  
120.27 newborn, and child-related public health data collection systems;

120.28 (iii) inform health care providers and the public of the prevalence, risks, conditions, and  
120.29 treatments associated with substance use disorders involving or affecting pregnancies,  
120.30 infants, and children; and

120.31 (iv) identify communities, families, infants, and children affected by substance use  
120.32 disorder in order to recommend focused interventions, prevention, and services.

121.1 (b) Individually identifiable data collected or maintained by the Department of Health  
121.2 under this subdivision is subject to the provisions of subdivision 9, paragraph (a).

121.3 Subd. 3. **Partnerships.** The commissioner of health may consult with sovereign Tribal  
121.4 nations, the Minnesota Departments of Human Services, Corrections, Public Safety, and  
121.5 Education, local public health agencies, care providers and insurers, community organizations  
121.6 that focus on substance abuse risks and recovery, individuals affected by substance use  
121.7 disorders, and any other individuals, entities, and organizations as necessary to carry out  
121.8 the goals of this section.

121.9 Subd. 4. **Grants authorized.** (a) The commissioner of health may award grants, as  
121.10 funding allows, to entities and organizations focused on addressing and preventing the  
121.11 negative impacts of drug overdose and morbidity. Examples of activities the commissioner  
121.12 may consider for these grant awards include:

121.13 (1) developing, implementing, or promoting drug overdose and morbidity prevention  
121.14 programs and activities;

121.15 (2) community outreach and other efforts addressing the root causes of drug overdose  
121.16 and morbidity;

121.17 (3) identifying risk and protective factors relating to drug overdose and morbidity that  
121.18 contribute to identification, development, or improvement of prevention strategies and  
121.19 community outreach;

121.20 (4) developing or providing trauma-informed drug overdose and morbidity prevention  
121.21 and services;

121.22 (5) developing or providing culturally and linguistically appropriate drug overdose and  
121.23 morbidity prevention and services, and programs that target and serve historically underserved  
121.24 communities;

121.25 (6) working collaboratively with educational institutions, including school districts, to  
121.26 implement drug overdose and morbidity prevention strategies for students, teachers, and  
121.27 administrators;

121.28 (7) working collaboratively with sovereign Tribal nations, care providers, nonprofit  
121.29 organizations, for-profit organizations, government entities, community-based organizations,  
121.30 and other entities to implement substance misuse and drug overdose prevention strategies  
121.31 within their communities; and

121.32 (8) creating or implementing quality improvement initiatives to improve drug overdose  
121.33 and morbidity treatment and outcomes.

122.1 (b) Any organization or government entity receiving grant money under this section  
122.2 must collect and make available to the commissioner of health aggregate data related to the  
122.3 activity funded by the program under this section. The commissioner of health shall use the  
122.4 information and data from the program evaluation to inform the administration of existing  
122.5 Department of Health programming and the development of Department of Health policies,  
122.6 programs, and procedures.

122.7 Subd. 5. **Promotion; administration.** In fiscal years 2026 and beyond, the commissioner  
122.8 may spend up to 25 percent of the total funding appropriated to the comprehensive drug  
122.9 overdose and morbidity program in each fiscal year to promote, administer, support, and  
122.10 evaluate the programs authorized under this section and to provide technical assistance to  
122.11 program grantees.

122.12 Subd. 6. **External contributions.** The commissioner may accept contributions from  
122.13 governmental and nongovernmental sources and may apply for grants to supplement state  
122.14 appropriations for the programs authorized under this section. Contributions and grants  
122.15 received from the sources identified in this subdivision to advance the purpose of this section  
122.16 are appropriated to the commissioner for the comprehensive drug overdose and morbidity  
122.17 program.

122.18 Subd. 7. **Program evaluation.** Beginning February 28, 2024, the commissioner of health  
122.19 shall report every even-numbered year to the legislative committees with jurisdiction over  
122.20 health detailing the expenditures of funds authorized under this section. The commissioner  
122.21 shall use the data to evaluate the effectiveness of the program. The commissioner must  
122.22 include in the report:

122.23 (1) the number of organizations receiving grant money under this section;

122.24 (2) the number of individuals served by the grant programs;

122.25 (3) a description and analysis of the practices implemented by program grantees; and

122.26 (4) best practices recommendations to prevent drug overdose and morbidity, including  
122.27 culturally relevant best practices and recommendations focused on historically underserved  
122.28 communities.

122.29 Subd. 8. **Measurement.** Notwithstanding any law to the contrary, the commissioner of  
122.30 health shall assess and evaluate grants and contracts awarded using available data sources,  
122.31 including but not limited to the Minnesota All Payer Claims Database (MN APCD), the  
122.32 Minnesota Behavioral Risk Factor Surveillance System (BRFSS), the Minnesota Student

123.1 Survey, vital records, hospitalization data, syndromic surveillance, and the Minnesota  
123.2 Electronic Health Record Consortium.

123.3 Subd. 9. **Classification of data.** (a) Individually identifiable data collected or maintained  
123.4 by the comprehensive drug overdose and morbidity program under subdivision 2, paragraph  
123.5 (a), clause (8), are classified as private data on individuals, as defined in section 13.02,  
123.6 subdivision 3.

123.7 (b) Private data identified in paragraph (a) shall not be introduced into evidence in any  
123.8 administrative, civil, or criminal proceeding, or disclosed in response to discovery requests,  
123.9 subpoenas, or investigative demands. These disclosure and evidentiary restrictions only  
123.10 apply to data collected or maintained by the comprehensive drug overdose and morbidity  
123.11 program and do not apply to data obtained from alternative sources.

123.12 **Sec. 40. [144.0752] CULTURAL COMMUNICATIONS.**

123.13 Subdivision 1. **Establishment.** The commissioner of health shall establish:

123.14 (1) a cultural communications program that advances culturally and linguistically  
123.15 appropriate communication services for communities most impacted by health disparities  
123.16 which includes limited English proficient (LEP) populations, African American populations,  
123.17 LGBTQ+ populations, and people with disabilities; and

123.18 (2) a position that works with department leadership and division to ensure that the  
123.19 department follows the National Standards for Culturally and Linguistically Appropriate  
123.20 Services (CLAS) Standards.

123.21 Subd. 2. **Commissioner's duties.** The commissioner of health shall oversee a program  
123.22 to:

123.23 (1) align the department services, policies, procedures, and governance with the National  
123.24 CLAS Standards, establish culturally and linguistically appropriate goals, policies, and  
123.25 management accountability, and apply them throughout the organization's planning and  
123.26 operations;

123.27 (2) ensure the department services respond to the cultural and linguistic diversity of  
123.28 Minnesotans and that the department partners with the community to design, implement,  
123.29 and evaluate policies, practices, and services that are aligned with the national cultural and  
123.30 linguistic appropriateness standard; and

124.1 (3) ensure the department leadership, workforce, and partners embed culturally and  
124.2 linguistically appropriate policies and practices into leadership and public health program  
124.3 planning, intervention, evaluation, and dissemination.

124.4 Subd. 3. **Eligible contractors.** The commissioner may enter into contracts to implement  
124.5 this section. Organizations eligible to receive contract funding under this section include:

124.6 (1) master contractors that are selected through the state to provide language and  
124.7 communication services; and

124.8 (2) organizations that are able to provide services for languages that master contractors  
124.9 are unable to cover.

124.10 Sec. 41. **[144.0754] OFFICE OF AFRICAN AMERICAN HEALTH; DUTIES.**

124.11 Subdivision 1. **Establishment.** The commissioner shall establish the Office of African  
124.12 American Health to address the unique public health needs of African American Minnesotans  
124.13 and work to develop solutions and systems to address identified health disparities of African  
124.14 American Minnesotans arising from a context of cumulative and historical discrimination  
124.15 and disadvantages in multiple systems, including but not limited to housing, education,  
124.16 employment, gun violence, incarceration, environmental factors, and health care  
124.17 discrimination.

124.18 Subd. 2. **Duties of the office.** The office shall:

124.19 (1) convene the African American Health State Advisory Council (AAHSAC) under  
124.20 section 144.0755 to advise the commissioner on issues and to develop specific, targeted  
124.21 policy solutions to improve the health of African American Minnesotans, with a focus on  
124.22 United States-born African Americans;

124.23 (2) based upon input from and collaboration with the AAHSAC, health indicators, and  
124.24 identified disparities, conduct analysis and develop policy and program recommendations  
124.25 and solutions targeted at improving African American health outcomes;

124.26 (3) coordinate and conduct community engagement across multiple systems, sectors,  
124.27 and communities to address racial disparities in labor force participation, educational  
124.28 achievement, and involvement with the criminal justice system that impact African American  
124.29 health and well-being;

124.30 (4) conduct data analysis and research to support policy goals and solutions;

124.31 (5) award and administer African American health special emphasis grants to health and  
124.32 community-based organizations to plan and develop programs targeted at improving African

125.1 American health outcomes, based upon needs identified by the council, health indicators,  
125.2 and identified disparities and addressing historical trauma and systems of United States-born  
125.3 African American Minnesotans; and

125.4 (6) develop and administer Department of Health immersion experiences for students  
125.5 in secondary education and community colleges to improve diversity of the public health  
125.6 workforce and introduce career pathways that contribute to reducing health disparities.

125.7 Sec. 42. [144.0755] AFRICAN AMERICAN HEALTH STATE ADVISORY  
125.8 COUNCIL.

125.9 Subdivision 1. Establishment; purpose. The commissioner of health shall establish  
125.10 and administer the African American Health State Advisory Council to advise the  
125.11 commissioner on implementing specific strategies to reduce health inequities and disparities  
125.12 that particularly affect African Americans in Minnesota.

125.13 Subd. 2. Members. (a) The council shall include no fewer than 12 or more than 20  
125.14 members from any of the following groups:

125.15 (1) representatives of community-based organizations serving or advocating for African  
125.16 American citizens;

125.17 (2) at-large community leaders or elders, as nominated by other council members;

125.18 (3) African American individuals who provide and receive health care services;

125.19 (4) African American secondary or college students;

125.20 (5) health or human service professionals serving African American communities or  
125.21 clients;

125.22 (6) representatives with research or academic expertise in racial equity; and

125.23 (7) other members that the commissioner deems appropriate to facilitate the goals and  
125.24 duties of the council.

125.25 (b) The commissioner shall make recommendations for council membership and, after  
125.26 considering recommendations from the council, shall appoint a chair or chairs of the council.  
125.27 Council members shall be appointed by the governor.

125.28 Subd. 3. Terms. A term shall be for two years and appointees may be reappointed to  
125.29 serve two additional terms. The commissioner shall recommend appointments to replace  
125.30 members vacating their positions in a timely manner, no more than three months after the  
125.31 council reviews panel recommendations.

126.1 Subd. 4. **Duties of commissioner.** The commissioner or commissioner's designee shall:

126.2 (1) maintain and actively engage with the council established in this section;

126.3 (2) based on recommendations of the council, review identified department or other  
126.4 related policies or practices that maintain health inequities and disparities that particularly  
126.5 affect African Americans in Minnesota;

126.6 (3) in partnership with the council, recommend or implement action plans and resources  
126.7 necessary to address identified disparities and advance African American health equity;

126.8 (4) support interagency collaboration to advance African American health equity; and

126.9 (5) support member participation in the council, including participation in educational  
126.10 and community engagement events across Minnesota that specifically address African  
126.11 American health equity.

126.12 Subd. 5. **Duties of council.** The council shall:

126.13 (1) identify health disparities found in African American communities and contributing  
126.14 factors;

126.15 (2) recommend to the commissioner for review any statutes, rules, or administrative  
126.16 policies or practices that would address African American health disparities;

126.17 (3) recommend policies and strategies to the commissioner of health to address disparities  
126.18 specifically affecting African American health;

126.19 (4) form work groups of council members who are persons who provide and receive  
126.20 services and representatives of advocacy groups;

126.21 (5) provide the work groups with clear guidelines, standardized parameters, and tasks  
126.22 for the work groups to accomplish; and

126.23 (6) annually submit to the commissioner a report that summarizes the activities of the  
126.24 council, identifies disparities specially affecting the health of African American Minnesotans,  
126.25 and makes recommendations to address identified disparities.

126.26 Subd. 6. **Duties of council members.** The members of the council shall:

126.27 (1) attend scheduled meetings with no more than three absences per year, participate in  
126.28 scheduled meetings, and prepare for meetings by reviewing meeting notes;

126.29 (2) maintain open communication channels with respective constituencies;

126.30 (3) identify and communicate issues and risks that may impact the timely completion  
126.31 of tasks;

127.1 (4) participate in any activities the council or commissioner deems appropriate and  
127.2 necessary to facilitate the goals and duties of the council; and

127.3 (5) participate in work groups to carry out council duties.

127.4 Subd. 7. **Staffing; office space; equipment.** The commissioner shall provide the advisory  
127.5 council with staff support, office space, and access to office equipment and services.

127.6 Subd. 8. **Reimbursement.** Compensation and reimbursement for travel and expenses  
127.7 incurred for council activities are governed by section 15.059, subdivision 3.

127.8 Sec. 43. **[144.0756] AFRICAN AMERICAN HEALTH SPECIAL EMPHASIS GRANT**  
127.9 **PROGRAM.**

127.10 Subdivision 1. **Establishment.** The commissioner of health shall establish the African  
127.11 American health special emphasis grant program administered by the Office of African  
127.12 American Health. The purposes of the program are to:

127.13 (1) identify disparities impacting African American health arising from cumulative and  
127.14 historical discrimination and disadvantages in multiple systems, including but not limited  
127.15 to housing, education, employment, gun violence, incarceration, environmental factors, and  
127.16 health care discrimination; and

127.17 (2) develop community-based solutions that incorporate a multisector approach to  
127.18 addressing identified disparities impacting African American health.

127.19 Subd. 2. **Requests for proposals; accountability; data collection.** As directed by the  
127.20 commissioner of health, the Office of African American Health shall:

127.21 (1) develop a request for proposals for an African American health special emphasis  
127.22 grant program in consultation with community stakeholders;

127.23 (2) provide outreach, technical assistance, and program development guidance to potential  
127.24 qualifying organizations or entities;

127.25 (3) review responses to requests for proposals in consultation with community  
127.26 stakeholders and award grants under this section;

127.27 (4) establish a transparent and objective accountability process in consultation with  
127.28 community stakeholders, focused on outcomes that grantees agree to achieve;

127.29 (5) provide grantees with access to summary and other public data to assist grantees in  
127.30 establishing and implementing effective community-led solutions; and

127.31 (6) collect and maintain data on outcomes reported by grantees.

128.1 Subd. 3. **Eligible grantees.** Organizations eligible to receive grant funding under this  
128.2 section include nonprofit organizations or entities that work with African American  
128.3 communities or are focused on addressing disparities impacting the health of African  
128.4 American communities.

128.5 Subd. 4. **Strategic consideration and priority of proposals; grant awards.** In  
128.6 developing the requests for proposals and awarding the grants, the commissioner and the  
128.7 Office of African American Health shall consider building upon the existing capacity of  
128.8 communities and on developing capacity where it is lacking. Proposals shall focus on  
128.9 addressing health equity issues specific to United States-born African American communities;  
128.10 addressing the health impact of historical trauma; and reducing health disparities experienced  
128.11 by United States-born African American communities; and incorporating a multisector  
128.12 approach to addressing identified disparities.

128.13 Subd. 5. **Report.** Grantees must report grant program outcomes to the commissioner on  
128.14 the forms and according to timelines established by the commissioner.

128.15 **Sec. 44. [144.0757] OFFICE OF AMERICAN INDIAN HEALTH.**

128.16 Subdivision 1. **Duties.** The Office of American Indian Health is established to address  
128.17 unique public health needs of American Indian Tribal communities in Minnesota, and shall:

128.18 (1) coordinate with Minnesota's Tribal Nations and urban American Indian  
128.19 community-based organizations to identify underlying causes of health disparities, address  
128.20 unique health needs of Minnesota's Tribal communities, and develop public health approaches  
128.21 to achieve health equity;

128.22 (2) strengthen capacity of American Indian and community-based organizations and  
128.23 Tribal Nations to address identified health disparities and needs;

128.24 (3) administer state and federal grant funding opportunities targeted to improve the  
128.25 health of American Indians;

128.26 (4) provide overall leadership for targeted development of holistic health and wellness  
128.27 strategies to improve health and to support Tribal and urban American Indian public health  
128.28 leadership and self-sufficiency;

128.29 (5) provide technical assistance to Tribal and American Indian urban community leaders  
128.30 to develop culturally appropriate activities to address public health emergencies;

128.31 (6) develop and administer the department immersion experiences for American Indian  
128.32 students in secondary education and community colleges to improve diversity of the public

129.1 health workforce and introduce career pathways that contribute to reducing health disparities;  
129.2 and

129.3 (7) identify and promote workforce development strategies for Department of Health  
129.4 staff to work with the American Indian population and Tribal Nations more effectively in  
129.5 Minnesota.

129.6 Subd. 2. **Grants and contracts.** To carry out these duties, the office may contract with  
129.7 or provide grants to qualifying entities.

129.8 **Sec. 45. [144.0758] AMERICAN INDIAN HEALTH SPECIAL EMPHASIS GRANTS.**

129.9 Subdivision 1. **Establishment.** The commissioner of health shall establish the American  
129.10 Indian health special emphasis grant program. The purposes of the program are to:

129.11 (1) plan and develop programs targeted to address continuing and persistent health  
129.12 disparities of Minnesota's American Indian population and improve American Indian health  
129.13 outcomes based upon needs identified by health indicators and identified disparities;

129.14 (2) identify disparities in American Indian health arising from cumulative and historical  
129.15 discrimination; and

129.16 (3) plan and develop community-based solutions with a multisector approach to  
129.17 addressing identified disparities in American Indian health.

129.18 Subd. 2. **Commissioner's duties.** The commissioner of health shall:

129.19 (1) develop a request for proposals for an American Indian health special emphasis grant  
129.20 program in consultation with Minnesota's Tribal Nations and urban American Indian  
129.21 community-based organizations based upon needs identified by the community, health  
129.22 indicators, and identified disparities;

129.23 (2) provide outreach, technical assistance, and program development guidance to potential  
129.24 qualifying organizations or entities;

129.25 (3) review responses to requests for proposals in consultation with community  
129.26 stakeholders and award grants under this section;

129.27 (4) establish a transparent and objective accountability process in consultation with  
129.28 community stakeholders focused on outcomes that grantees agree to achieve;

129.29 (5) provide grantees with access to data to assist grantees in establishing and  
129.30 implementing effective community-led solutions; and

129.31 (6) collect and maintain data on outcomes reported by grantees.

130.1 Subd. 3. **Eligible grantees.** Organizations eligible to receive grant funding under this  
130.2 section are Minnesota's Tribal Nations and urban American Indian community-based  
130.3 organizations.

130.4 Subd. 4. **Strategic consideration and priority of proposals; grant awards.** In  
130.5 developing the proposals and awarding the grants, the commissioner shall consider building  
130.6 upon the existing capacity of Minnesota's Tribal Nations and urban American Indian  
130.7 community-based organizations and on developing capacity where it is lacking. Proposals  
130.8 may focus on addressing health equity issues specific to Tribal and urban American Indian  
130.9 communities; addressing the health impact of historical trauma; reducing health disparities  
130.10 experienced by American Indian communities; and incorporating a multisector approach  
130.11 to addressing identified disparities.

130.12 Subd. 5. **Report.** Grantees must report grant program outcomes to the commissioner on  
130.13 the forms and according to the timelines established by the commissioner.

130.14 Sec. 46. Minnesota Statutes 2022, section 144.122, is amended to read:

130.15 **144.122 LICENSE, PERMIT, AND SURVEY FEES.**

130.16 (a) The state commissioner of health, by rule, may prescribe procedures and fees for  
130.17 filing with the commissioner as prescribed by statute and for the issuance of original and  
130.18 renewal permits, licenses, registrations, and certifications issued under authority of the  
130.19 commissioner. The expiration dates of the various licenses, permits, registrations, and  
130.20 certifications as prescribed by the rules shall be plainly marked thereon. Fees may include  
130.21 application and examination fees and a penalty fee for renewal applications submitted after  
130.22 the expiration date of the previously issued permit, license, registration, and certification.  
130.23 The commissioner may also prescribe, by rule, reduced fees for permits, licenses,  
130.24 registrations, and certifications when the application therefor is submitted during the last  
130.25 three months of the permit, license, registration, or certification period. Fees proposed to  
130.26 be prescribed in the rules shall be first approved by the Department of Management and  
130.27 Budget. All fees proposed to be prescribed in rules shall be reasonable. The fees shall be  
130.28 in an amount so that the total fees collected by the commissioner will, where practical,  
130.29 approximate the cost to the commissioner in administering the program. All fees collected  
130.30 shall be deposited in the state treasury and credited to the state government special revenue  
130.31 fund unless otherwise specifically appropriated by law for specific purposes.

130.32 (b) The commissioner may charge a fee for voluntary certification of medical laboratories  
130.33 and environmental laboratories, and for environmental and medical laboratory services  
130.34 provided by the department, without complying with paragraph (a) or chapter 14. Fees

131.1 charged for environment and medical laboratory services provided by the department must  
131.2 be approximately equal to the costs of providing the services.

131.3 (c) The commissioner may develop a schedule of fees for diagnostic evaluations  
131.4 conducted at clinics held by the services for children with disabilities program. All receipts  
131.5 generated by the program are annually appropriated to the commissioner for use in the  
131.6 maternal and child health program.

131.7 (d) The commissioner shall set license fees for hospitals and nursing homes that are not  
131.8 boarding care homes at the following levels:

131.9	Joint Commission on Accreditation of	\$7,655 plus \$16 per bed
131.10	Healthcare Organizations (JCAHO) and	
131.11	American Osteopathic Association (AOA)	
131.12	hospitals	
131.13	Non-JCAHO and non-AOA hospitals	\$5,280 plus \$250 per bed
131.14	Nursing home	\$183 plus \$91 per bed until June 30, 2018.
131.15		\$183 plus \$100 per bed between July 1, 2018,
131.16		and June 30, 2020. \$183 plus \$105 per bed
131.17		beginning July 1, 2020.

131.18 The commissioner shall set license fees for outpatient surgical centers, boarding care  
131.19 homes, supervised living facilities, assisted living facilities, and assisted living facilities  
131.20 with dementia care at the following levels:

131.21	Outpatient surgical centers	\$3,712
131.22	Boarding care homes	\$183 plus \$91 per bed
131.23	Supervised living facilities	\$183 plus \$91 per bed.
131.24	Assisted living facilities with dementia care	\$3,000 plus \$100 per resident.
131.25	Assisted living facilities	\$2,000 plus \$75 per resident.

131.26 Fees collected under this paragraph are nonrefundable. The fees are nonrefundable even if  
131.27 received before July 1, 2017, for licenses or registrations being issued effective July 1, 2017,  
131.28 or later.

131.29 (e) Unless prohibited by federal law, the commissioner of health shall charge applicants  
131.30 the following fees to cover the cost of any initial certification surveys required to determine  
131.31 a provider's eligibility to participate in the Medicare or Medicaid program:

131.32	Prospective payment surveys for hospitals	\$	900
131.33	Swing bed surveys for nursing homes	\$	1,200
131.34	Psychiatric hospitals	\$	1,400
131.35	Rural health facilities	\$	1,100
131.36	Portable x-ray providers	\$	500

132.1	Home health agencies	\$	1,800
132.2	Outpatient therapy agencies	\$	800
132.3	End stage renal dialysis providers	\$	2,100
132.4	Independent therapists	\$	800
132.5	Comprehensive rehabilitation outpatient facilities	\$	1,200
132.6	Hospice providers	\$	1,700
132.7	Ambulatory surgical providers	\$	1,800
132.8	Hospitals	\$	4,200
132.9	Other provider categories or additional	Actual surveyor costs: average	
132.10	resurveys required to complete initial	surveyor cost x number of hours for	
132.11	certification	the survey process.	

132.12 These fees shall be submitted at the time of the application for federal certification and  
 132.13 shall not be refunded. All fees collected after the date that the imposition of fees is not  
 132.14 prohibited by federal law shall be deposited in the state treasury and credited to the state  
 132.15 government special revenue fund.

132.16 (f) Notwithstanding section 16A.1283, the commissioner may adjust the fees assessed  
 132.17 on assisted living facilities and assisted living facilities with dementia care under paragraph  
 132.18 (d), in a revenue-neutral manner in accordance with the requirements of this paragraph:

132.19 (1) a facility seeking to renew a license shall pay a renewal fee in an amount that is up  
 132.20 to ten percent lower than the applicable fee in paragraph (d) if residents who receive home  
 132.21 and community-based waiver services under chapter 256S and section 256B.49 comprise  
 132.22 more than 50 percent of the facility's capacity in the calendar year prior to the year in which  
 132.23 the renewal application is submitted; and

132.24 (2) a facility seeking to renew a license shall pay a renewal fee in an amount that is up  
 132.25 to ten percent higher than the applicable fee in paragraph (d) if residents who receive home  
 132.26 and community-based waiver services under chapter 256S and section 256B.49 comprise  
 132.27 less than 50 percent of the facility's capacity during the calendar year prior to the year in  
 132.28 which the renewal application is submitted.

132.29 The commissioner may annually adjust the percentages in clauses (1) and (2), to ensure this  
 132.30 paragraph is implemented in a revenue-neutral manner. The commissioner shall develop a  
 132.31 method for determining capacity thresholds in this paragraph in consultation with the  
 132.32 commissioner of human services and must coordinate the administration of this paragraph  
 132.33 with the commissioner of human services for purposes of verification.

132.34 (g) The commissioner shall charge hospitals an annual licensing base fee of \$1,826 per  
 132.35 hospital, plus an additional \$23 per licensed bed or bassinets fee. Revenue shall be deposited

133.1 to the state government special revenue fund and credited toward trauma hospital designations  
133.2 under sections 144.605 and 144.6071.

133.3 Sec. 47. Minnesota Statutes 2022, section 144.1481, subdivision 1, is amended to read:

133.4 Subdivision 1. **Establishment; membership.** The commissioner of health shall establish  
133.5 a ~~16-member~~ 21-member Rural Health Advisory Committee. The committee shall consist  
133.6 of the following members, all of whom must reside outside the seven-county metropolitan  
133.7 area, as defined in section 473.121, subdivision 2:

133.8 (1) two members from the house of representatives of the state of Minnesota, one from  
133.9 the majority party and one from the minority party;

133.10 (2) two members from the senate of the state of Minnesota, one from the majority party  
133.11 and one from the minority party;

133.12 (3) a volunteer member of an ambulance service based outside the seven-county  
133.13 metropolitan area;

133.14 (4) a representative of a hospital located outside the seven-county metropolitan area;

133.15 (5) a representative of a nursing home located outside the seven-county metropolitan  
133.16 area;

133.17 (6) a medical doctor or doctor of osteopathic medicine licensed under chapter 147;

133.18 (7) a dentist licensed under chapter 150A or other oral health professional if a dentist is  
133.19 not available to participate;

133.20 (8) ~~a midlevel practitioner~~ an advanced practice professional;

133.21 (9) a registered nurse or licensed practical nurse;

133.22 (10) a licensed health care professional from an occupation not otherwise represented  
133.23 on the committee;

133.24 (11) a representative of an institution of higher education located outside the seven-county  
133.25 metropolitan area that provides training for rural health care providers; ~~and~~

133.26 (12) a member of a Tribal nation;

133.27 (13) a representative of a local public health agency or community health board;

133.28 (14) a health professional or advocate with experience working with people with mental  
133.29 illness;

134.1 (15) a representative of a community organization that works with individuals  
134.2 experiencing health disparities;

134.3 (16) an individual with expertise in economic development, or an employer working  
134.4 outside the seven-county metropolitan area; and

134.5 ~~(12)~~ (17) three consumers, at least one of whom must be an advocate for persons who  
134.6 ~~are mentally ill or developmentally disabled~~ from a community experiencing health  
134.7 disparities.

134.8 The commissioner will make recommendations for committee membership. Committee  
134.9 members will be appointed by the governor. In making appointments, the governor shall  
134.10 ensure that appointments provide geographic balance among those areas of the state outside  
134.11 the seven-county metropolitan area. The chair of the committee shall be elected by the  
134.12 members. The advisory committee is governed by section 15.059, except that the members  
134.13 do not receive per diem compensation.

134.14 Sec. 48. Minnesota Statutes 2022, section 144.1501, subdivision 1, is amended to read:

134.15 Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions  
134.16 apply.

134.17 (b) "Advanced dental therapist" means an individual who is licensed as a dental therapist  
134.18 under section 150A.06, and who is certified as an advanced dental therapist under section  
134.19 150A.106.

134.20 (c) "Alcohol and drug counselor" means an individual who is licensed as an alcohol and  
134.21 drug counselor under chapter 148F.

134.22 (d) "Dental therapist" means an individual who is licensed as a dental therapist under  
134.23 section 150A.06.

134.24 (e) "Dentist" means an individual who is licensed to practice dentistry.

134.25 (f) "Designated rural area" means a statutory and home rule charter city or township that  
134.26 is outside the seven-county metropolitan area as defined in section 473.121, subdivision 2,  
134.27 excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

134.28 (g) "Emergency circumstances" means those conditions that make it impossible for the  
134.29 participant to fulfill the service commitment, including death, total and permanent disability,  
134.30 or temporary disability lasting more than two years.

134.31 (h) "Hospital nurse" means an individual who is licensed as a registered nurse and who  
134.32 is providing direct patient care in a nonprofit hospital setting.

135.1 (i) "Mental health professional" means an individual providing clinical services in the  
135.2 treatment of mental illness who is qualified in at least one of the ways specified in section  
135.3 245.462, subdivision 18.

135.4 ~~(i)~~ (j) "Medical resident" means an individual participating in a medical residency in  
135.5 family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

135.6 ~~(i)~~ (k) "Midlevel practitioner" means a nurse practitioner, nurse-midwife, nurse  
135.7 anesthetist, advanced clinical nurse specialist, or physician assistant.

135.8 ~~(k)~~ (l) "Nurse" means an individual who has completed training and received all licensing  
135.9 or certification necessary to perform duties as a licensed practical nurse or registered nurse.

135.10 ~~(k)~~ (m) "Nurse-midwife" means a registered nurse who has graduated from a program  
135.11 of study designed to prepare registered nurses for advanced practice as nurse-midwives.

135.12 ~~(m)~~ (n) "Nurse practitioner" means a registered nurse who has graduated from a program  
135.13 of study designed to prepare registered nurses for advanced practice as nurse practitioners.

135.14 ~~(n)~~ (o) "Pharmacist" means an individual with a valid license issued under chapter 151.

135.15 ~~(o)~~ (p) "Physician" means an individual who is licensed to practice medicine in the areas  
135.16 of family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

135.17 ~~(p)~~ (q) "Physician assistant" means a person licensed under chapter 147A.

135.18 (r) "PSLF program" means the federal Public Service Loan Forgiveness program  
135.19 established under Code of Federal Regulations, title 34, section 685.219.

135.20 ~~(q)~~ (s) "Public health nurse" means a registered nurse licensed in Minnesota who has  
135.21 obtained a registration certificate as a public health nurse from the Board of Nursing in  
135.22 accordance with Minnesota Rules, chapter 6316.

135.23 ~~(s)~~ (t) "Qualified educational loan" means a government, commercial, or foundation loan  
135.24 for actual costs paid for tuition, reasonable education expenses, and reasonable living  
135.25 expenses related to the graduate or undergraduate education of a health care professional.

135.26 ~~(s)~~ (u) "Underserved urban community" means a Minnesota urban area or population  
135.27 included in the list of designated primary medical care health professional shortage areas  
135.28 (HPSAs), medically underserved areas (MUAs), or medically underserved populations  
135.29 (MUPs) maintained and updated by the United States Department of Health and Human  
135.30 Services.

136.1 Sec. 49. Minnesota Statutes 2022, section 144.1501, subdivision 2, is amended to read:

136.2 Subd. 2. **Creation of account.** (a) A health professional education loan forgiveness  
136.3 program account is established. The commissioner of health shall use money from the  
136.4 account to establish a loan forgiveness program:

136.5 (1) for medical residents, mental health professionals, and alcohol and drug counselors  
136.6 agreeing to practice in designated rural areas or underserved urban communities or  
136.7 specializing in the area of pediatric psychiatry;

136.8 (2) for midlevel practitioners agreeing to practice in designated rural areas or to teach  
136.9 at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program  
136.10 at the undergraduate level or the equivalent at the graduate level;

136.11 (3) for nurses who agree to practice in a Minnesota nursing home; an intermediate care  
136.12 facility for persons with developmental disability; a hospital if the hospital owns and operates  
136.13 a Minnesota nursing home and a minimum of 50 percent of the hours worked by the nurse  
136.14 is in the nursing home; a housing with services establishment as defined in section 144D.01,  
136.15 subdivision 4; or for a home care provider as defined in section 144A.43, subdivision 4; or  
136.16 agree to teach at least 12 credit hours, or 720 hours per year in the nursing field in a  
136.17 postsecondary program at the undergraduate level or the equivalent at the graduate level;

136.18 (4) for other health care technicians agreeing to teach at least 12 credit hours, or 720  
136.19 hours per year in their designated field in a postsecondary program at the undergraduate  
136.20 level or the equivalent at the graduate level. The commissioner, in consultation with the  
136.21 Healthcare Education-Industry Partnership, shall determine the health care fields where the  
136.22 need is the greatest, including, but not limited to, respiratory therapy, clinical laboratory  
136.23 technology, radiologic technology, and surgical technology;

136.24 (5) for pharmacists, advanced dental therapists, dental therapists, and public health nurses  
136.25 who agree to practice in designated rural areas; ~~and~~

136.26 (6) for dentists agreeing to deliver at least 25 percent of the dentist's yearly patient  
136.27 encounters to state public program enrollees or patients receiving sliding fee schedule  
136.28 discounts through a formal sliding fee schedule meeting the standards established by the  
136.29 United States Department of Health and Human Services under Code of Federal Regulations,  
136.30 title 42, section 51, chapter 303-; and

136.31 (7) for nurses who are enrolled in the PSLF program, employed as a hospital nurse by  
136.32 a nonprofit hospital that is an eligible employer under the PSLF program, and providing  
136.33 direct care to patients at the nonprofit hospital.

137.1 (b) Appropriations made to the account do not cancel and are available until expended,  
137.2 except that at the end of each biennium, any remaining balance in the account that is not  
137.3 committed by contract and not needed to fulfill existing commitments shall cancel to the  
137.4 fund.

137.5 Sec. 50. Minnesota Statutes 2022, section 144.1501, subdivision 3, is amended to read:

137.6 Subd. 3. **Eligibility.** (a) To be eligible to participate in the loan forgiveness program, an  
137.7 individual must:

137.8 (1) be a medical or dental resident; a licensed pharmacist; or be enrolled in a training or  
137.9 education program to become a dentist, dental therapist, advanced dental therapist, mental  
137.10 health professional, alcohol and drug counselor, pharmacist, public health nurse, midlevel  
137.11 practitioner, registered nurse, or a licensed practical nurse. The commissioner may also  
137.12 consider applications submitted by graduates in eligible professions who are licensed and  
137.13 in practice; and

137.14 (2) submit an application to the commissioner of health. Nurses applying under  
137.15 subdivision 2, paragraph (a), clause (7), must also include proof that the applicant is enrolled  
137.16 in the PSLF program and confirmation that the applicant is employed as a hospital nurse.

137.17 (b) An applicant selected to participate must sign a contract to agree to serve a minimum  
137.18 three-year full-time service obligation according to subdivision 2, which shall begin no later  
137.19 than March 31 following completion of required training, with the exception of:

137.20 (1) a nurse, who must agree to serve a minimum two-year full-time service obligation  
137.21 according to subdivision 2, which shall begin no later than March 31 following completion  
137.22 of required training;

137.23 (2) a nurse selected under subdivision 2, paragraph (a), clause (7), who must agree to  
137.24 continue as a hospital nurse for the repayment period of the participant's eligible loan under  
137.25 the PSLF program; and

137.26 (3) a nurse who agrees to teach according to subdivision 2, paragraph (a), clause (3),  
137.27 who must sign a contract to agree to teach for a minimum of two years.

137.28 Sec. 51. Minnesota Statutes 2022, section 144.1501, subdivision 4, is amended to read:

137.29 Subd. 4. **Loan forgiveness.** (a) The commissioner of health may select applicants each  
137.30 year for participation in the loan forgiveness program, within the limits of available funding.  
137.31 In considering applications, the commissioner shall give preference to applicants who  
137.32 document diverse cultural competencies. The commissioner shall distribute available funds

138.1 for loan forgiveness proportionally among the eligible professions according to the vacancy  
138.2 rate for each profession in the required geographic area, facility type, teaching area, patient  
138.3 group, or specialty type specified in subdivision 2, except for hospital nurses. The  
138.4 commissioner shall allocate funds for physician loan forgiveness so that 75 percent of the  
138.5 funds available are used for rural physician loan forgiveness and 25 percent of the funds  
138.6 available are used for underserved urban communities and pediatric psychiatry loan  
138.7 forgiveness. If the commissioner does not receive enough qualified applicants each year to  
138.8 use the entire allocation of funds for any eligible profession, the remaining funds may be  
138.9 allocated proportionally among the other eligible professions according to the vacancy rate  
138.10 for each profession in the required geographic area, patient group, or facility type specified  
138.11 in subdivision 2. Applicants are responsible for securing their own qualified educational  
138.12 loans. The commissioner shall select participants based on their suitability for practice  
138.13 serving the required geographic area or facility type specified in subdivision 2, as indicated  
138.14 by experience or training. The commissioner shall give preference to applicants closest to  
138.15 completing their training. Except as specified in paragraphs (b) and (c), for each year that  
138.16 a participant meets the service obligation required under subdivision 3, up to a maximum  
138.17 of four years, the commissioner shall make annual disbursements directly to the participant  
138.18 equivalent to 15 percent of the average educational debt for indebted graduates in their  
138.19 profession in the year closest to the applicant's selection for which information is available,  
138.20 not to exceed the balance of the participant's qualifying educational loans. Before receiving  
138.21 loan repayment disbursements and as requested, the participant must complete and return  
138.22 to the commissioner a confirmation of practice form provided by the commissioner verifying  
138.23 that the participant is practicing as required under subdivisions 2 and 3. The participant  
138.24 must provide the commissioner with verification that the full amount of loan repayment  
138.25 disbursement received by the participant has been applied toward the designated loans.  
138.26 After each disbursement, verification must be received by the commissioner and approved  
138.27 before the next loan repayment disbursement is made. Participants who move their practice  
138.28 remain eligible for loan repayment as long as they practice as required under subdivision  
138.29 2.

138.30 (b) For hospital nurses, the commissioner of health shall select applicants each year for  
138.31 participation in the hospital nursing education loan forgiveness program, within limits of  
138.32 available funding for hospital nurses. Applicants are responsible for applying for and  
138.33 maintaining eligibility for the PSLF program. For each year that a participant meets the  
138.34 eligibility requirements described in subdivision 3, the commissioner shall make an annual  
138.35 disbursement directly to the participant in an amount equal to the minimum loan payments  
138.36 required to be paid by the participant under the participant's repayment plan established for

139.1 the participant under the PSLF program for the previous loan year. Before receiving the  
139.2 annual loan repayment disbursement, the participant must complete and return to the  
139.3 commissioner a confirmation of practice form provided by the commissioner, verifying that  
139.4 the participant continues to meet the eligibility requirements under subdivision 3. The  
139.5 participant must provide the commissioner with verification that the full amount of loan  
139.6 repayment disbursement received by the participant has been applied toward the loan for  
139.7 which forgiveness is sought under the PSLF program.

139.8 (c) For each year that a participant who is a nurse and who has agreed to teach according  
139.9 to subdivision 2 meets the teaching obligation required in subdivision 3, the commissioner  
139.10 shall make annual disbursements directly to the participant equivalent to 15 percent of the  
139.11 average annual educational debt for indebted graduates in the nursing profession in the year  
139.12 closest to the participant's selection for which information is available, not to exceed the  
139.13 balance of the participant's qualifying educational loans.

139.14 Sec. 52. Minnesota Statutes 2022, section 144.1501, subdivision 5, is amended to read:

139.15 Subd. 5. **Penalty for nonfulfillment.** If a participant does not fulfill the required  
139.16 minimum commitment of service according to subdivision 3, or for hospital nurses, if the  
139.17 secretary of education determines that the participant does not meet eligibility requirements  
139.18 for the PSLF, the commissioner of health shall collect from the participant the total amount  
139.19 paid to the participant under the loan forgiveness program plus interest at a rate established  
139.20 according to section 270C.40. The commissioner shall deposit the money collected in the  
139.21 health care access fund to be credited to the health professional education loan forgiveness  
139.22 program account established in subdivision 2. The commissioner shall allow waivers of all  
139.23 or part of the money owed the commissioner as a result of a nonfulfillment penalty if  
139.24 emergency circumstances prevented fulfillment of the minimum service commitment, or  
139.25 for hospital nurses, if the PSLF program is discontinued before the participant's service  
139.26 commitment is fulfilled.

139.27 Sec. 53. **[144.1504] EMPLOYEE RECRUITMENT EDUCATION LOAN**  
139.28 **FORGIVENESS PROGRAM.**

139.29 Subdivision 1. Definitions. (a) For purposes of this section, the following terms have  
139.30 the meanings given.

139.31 (b) "Designated rural area" means a statutory or home rule charter city or township that  
139.32 is outside the seven-county metropolitan area as defined in section 473.121, subdivision 2,  
139.33 excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

140.1 (c) "Emergency circumstances" means those conditions that make it impossible for the  
140.2 participant to fulfill the service commitment, including death, total and permanent disability,  
140.3 or temporary disability lasting more than two years.

140.4 (d) "Nurse practitioner" means a registered nurse who has graduated from a program of  
140.5 study designed to prepare registered nurses for advanced practice as nurse practitioners.

140.6 (e) "Physician" means an individual who is licensed to practice medicine in the areas of  
140.7 family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

140.8 (f) "Physician assistant" means a person licensed under chapter 147A.

140.9 (g) "Qualified educational loan" means a government, commercial, or foundation loan  
140.10 for actual costs paid for tuition, reasonable education expenses, and reasonable living  
140.11 expenses related to the graduate or undergraduate education of a health care professional.

140.12 Subd. 2. **Creation of account.** (a) A health professional employee education loan  
140.13 forgiveness program account is established. The commissioner of health shall use money  
140.14 from the account to make grants to eligible providers for a loan forgiveness recruitment and  
140.15 retention program. Nominations for loan forgiveness through a grant shall be available to  
140.16 employees who are nurse practitioners, physicians, or physician assistants who agree to  
140.17 practice in designated rural areas that are included in a health profession's shortage area,  
140.18 where the provider rate per 10,000 population is less than ten and the vacancy rate has  
140.19 reached a level determined by the commissioner.

140.20 (b) Appropriations made to the account do not cancel and are available until expended,  
140.21 except that, at the end of each biennium, any remaining balance in the account that is not  
140.22 committed by contract and not needed to fulfill existing commitments shall cancel to the  
140.23 general fund.

140.24 Subd. 3. **Eligibility.** (a) Eligible providers must provide services in designated rural  
140.25 areas that are included in a health profession's shortage area where the provider rate per  
140.26 10,000 population is less than ten and the vacancy rate has reached a level determined by  
140.27 the commissioner for nurse practitioners, physicians, or physician assistants.

140.28 (b) Employees, as described in subdivision 2, paragraph (a), selected to receive loan  
140.29 forgiveness must agree to work a minimum average of 30 hours per week for a minimum  
140.30 of five years for a qualifying provider organization to maintain eligibility for loan forgiveness  
140.31 under this section.

140.32 Subd. 4. **Request for proposals.** The commissioner shall publish request for proposals  
140.33 that specify qualifying provider eligibility requirements; criteria for a qualifying employee

141.1 loan forgiveness recruitment program; provider selection criteria; documentation required  
141.2 for program participation; maximum number of loan forgiveness slots available per eligible  
141.3 provider; and methods of evaluation. The commissioner must publish additional requests  
141.4 for proposals each year in which funding is available for this purpose.

141.5 Subd. 5. **Application requirements.** (a) Eligible providers seeking loan forgiveness for  
141.6 employees shall submit an application to the commissioner. Applications from eligible  
141.7 providers must contain a complete description of the employee loan forgiveness program  
141.8 being proposed by the applicant, the process for determining which employees are eligible  
141.9 for loan forgiveness, and any special circumstances related to the provider that make it  
141.10 difficult to recruit and retain qualified employees. Eligible providers must submit the names  
141.11 of their employees to be considered for loan forgiveness.

141.12 (b) An employee whose name has been submitted to the commissioner and who wishes  
141.13 to apply for loan forgiveness must submit an application to the commissioner that must  
141.14 include employee practice site information and verification of employee qualified educational  
141.15 loan debt. The employee is responsible for securing the employee's qualified educational  
141.16 loans.

141.17 Subd. 6. **Selection process.** The commissioner shall determine a maximum number of  
141.18 loan forgiveness slots available per eligible provider and shall make selections based on the  
141.19 information provided in the grant application, including the demonstrated need for an  
141.20 applicant provider to enhance the retention of its workforce, the proposed employee loan  
141.21 forgiveness selection process, and other criteria as determined by the commissioner.

141.22 Subd. 7. **Reporting requirements.** (a) Participating providers whose employees receive  
141.23 loan forgiveness shall submit a report to the commissioner on a schedule determined by the  
141.24 commissioner and on a form supplied by the commissioner. The report must include the  
141.25 number of employees receiving loan forgiveness and, for each employee receiving loan  
141.26 forgiveness, the employee's name, current position, and average number of hours worked  
141.27 per week. During the loan forgiveness period, the commissioner may require and collect  
141.28 from participating providers and employees receiving loan forgiveness other information  
141.29 necessary to evaluate the program and ensure ongoing eligibility.

141.30 (b) Before receiving loan repayment disbursements, the employee must complete and  
141.31 return to the commissioner a confirmation of practice form provided by the commissioner  
141.32 verifying that the employee is practicing as required in subdivision 3. The employee must  
141.33 provide the commissioner with verification that the full amount of loan repayment  
141.34 disbursement received by the employee has been applied toward the designated loans. After

142.1 each disbursement, verification must be received by the commissioner and approved before  
142.2 the next loan repayment disbursement is made. Employees who move to a different eligible  
142.3 provider remain eligible for loan repayment as long as they practice as required in subdivision  
142.4 3.

142.5 Subd. 8. **Penalty for nonfulfillment.** If an employee does not fulfill the required  
142.6 minimum service commitment in subdivision 3, the commissioner shall collect from the  
142.7 employee the total amount paid to the employee under the loan forgiveness program, plus  
142.8 interest at a rate established according to section 270C.40. The commissioner shall deposit  
142.9 the money collected in an account in the special revenue fund and money in that account  
142.10 is annually appropriated to the commissioner for purposes of this section. The commissioner  
142.11 may allow waivers of all or part of the money owed to the commissioner as a result of a  
142.12 nonfulfillment penalty if emergency circumstances prevented fulfillment of the minimum  
142.13 service commitment.

142.14 Subd. 9. **Rules.** The commissioner may adopt rules to implement this section.

142.15 Sec. 54. Minnesota Statutes 2022, section 144.1505, is amended to read:

142.16 **144.1505 HEALTH PROFESSIONALS CLINICAL TRAINING EXPANSION**  
142.17 **AND RURAL AND UNDERSERVED CLINICAL ROTATIONS GRANT PROGRAM**  
142.18 **PROGRAMS.**

142.19 Subdivision 1. **Definitions.** For purposes of this section, the following definitions apply:

142.20 (1) "eligible advanced practice registered nurse program" means a program that is located  
142.21 in Minnesota and is currently accredited as a master's, doctoral, or postgraduate level  
142.22 advanced practice registered nurse program by the Commission on Collegiate Nursing  
142.23 Education or by the Accreditation Commission for Education in Nursing, or is a candidate  
142.24 for accreditation;

142.25 (2) "eligible dental therapy program" means a dental therapy education program or  
142.26 advanced dental therapy education program that is located in Minnesota and is either:

142.27 (i) approved by the Board of Dentistry; or

142.28 (ii) currently accredited by the Commission on Dental Accreditation;

142.29 (3) "eligible mental health professional program" means a program that is located in  
142.30 Minnesota and is listed as a mental health professional program by the appropriate accrediting  
142.31 body for clinical social work, psychology, marriage and family therapy, or licensed  
142.32 professional clinical counseling, or is a candidate for accreditation;

143.1 (4) "eligible pharmacy program" means a program that is located in Minnesota and is  
143.2 currently accredited as a doctor of pharmacy program by the Accreditation Council on  
143.3 Pharmacy Education;

143.4 (5) "eligible physician assistant program" means a program that is located in Minnesota  
143.5 and is currently accredited as a physician assistant program by the Accreditation Review  
143.6 Commission on Education for the Physician Assistant, or is a candidate for accreditation;

143.7 (6) "mental health professional" means an individual providing clinical services in the  
143.8 treatment of mental illness who meets one of the qualifications under section 245.462,  
143.9 subdivision 18; ~~and~~

143.10 (7) "eligible physician training program" means a physician residency training program  
143.11 located in Minnesota and that is currently accredited by the accrediting body or has presented  
143.12 a credible plan as a candidate for accreditation;

143.13 (8) "eligible dental program" means a dental education program or a dental residency  
143.14 training program located in Minnesota and that is currently accredited by the accrediting  
143.15 body or has presented a credible plan as a candidate for accreditation; and

143.16 ~~(7)~~ (9) "project" means a project to establish or expand clinical training for physician  
143.17 assistants, advanced practice registered nurses, pharmacists, dental therapists, advanced  
143.18 dental therapists, or mental health professionals in Minnesota.

143.19 Subd. 2. **Program Programs.** (a) For advanced practice provider clinical training  
143.20 expansion grants, the commissioner of health shall award health professional training site  
143.21 grants to eligible physician assistant, advanced practice registered nurse, pharmacy, dental  
143.22 therapy, and mental health professional programs to plan and implement expanded clinical  
143.23 training. A planning grant shall not exceed \$75,000, and a training grant shall not exceed  
143.24 \$150,000 for the first year, \$100,000 for the second year, and \$50,000 for the third year per  
143.25 program.

143.26 (b) For health professional rural and underserved clinical rotations grants, the  
143.27 commissioner of health shall award health professional training site grants to eligible  
143.28 physician, physician assistant, advanced practice registered nurse, pharmacy, dentistry,  
143.29 dental therapy, and mental health professional programs to augment existing clinical training  
143.30 programs to add rural and underserved rotations or clinical training experiences, such as  
143.31 credential or certificate rural tracks or other specialized training. For physician and dentist  
143.32 training, the expanded training must include rotations in primary care settings such as  
143.33 community clinics, hospitals, health maintenance organizations, or practices in rural  
143.34 communities.

144.1 ~~(b)~~ (c) Funds may be used for:

144.2 (1) establishing or expanding rotations and clinical training ~~for physician assistants,~~  
144.3 ~~advanced practice registered nurses, pharmacists, dental therapists, advanced dental therapists,~~  
144.4 ~~and mental health professionals in Minnesota;~~

144.5 (2) recruitment, training, and retention of students and faculty;

144.6 (3) connecting students with appropriate clinical training sites, internships, practicums,  
144.7 or externship activities;

144.8 (4) travel and lodging for students;

144.9 (5) faculty, student, and preceptor salaries, incentives, or other financial support;

144.10 (6) development and implementation of cultural competency training;

144.11 (7) evaluations;

144.12 (8) training site improvements, fees, equipment, and supplies required to establish,  
144.13 maintain, or expand ~~a physician assistant, advanced practice registered nurse, pharmacy,~~  
144.14 ~~dental therapy, or mental health professional~~ training program; and

144.15 (9) supporting clinical education in which trainees are part of a primary care team model.

144.16 Subd. 3. **Applications.** Eligible physician assistant, advanced practice registered nurse,  
144.17 pharmacy, dental therapy, and mental health professional programs and physician and dental  
144.18 programs seeking a grant shall apply to the commissioner. Applications must include a  
144.19 description of the number of additional students who will be trained using grant funds;  
144.20 attestation that funding will be used to support an increase in the number of clinical training  
144.21 slots; a description of the problem that the proposed project will address; a description of  
144.22 the project, including all costs associated with the project, sources of funds for the project,  
144.23 detailed uses of all funds for the project, and the results expected; and a plan to maintain or  
144.24 operate any component included in the project after the grant period. The applicant must  
144.25 describe achievable objectives, a timetable, and roles and capabilities of responsible  
144.26 individuals in the organization. Applicants applying under subdivision 2, paragraph (b),  
144.27 must include information about length of training and training site settings, geographic  
144.28 location of rural sites, and rural populations expected to be served.

144.29 Subd. 4. **Consideration of applications.** The commissioner shall review each application  
144.30 to determine whether or not the application is complete and whether the program and the  
144.31 project are eligible for a grant. In evaluating applications, the commissioner shall score each  
144.32 application based on factors including, but not limited to, the applicant's clarity and

145.1 thoroughness in describing the project and the problems to be addressed, the extent to which  
145.2 the applicant has demonstrated that the applicant has made adequate provisions to ensure  
145.3 proper and efficient operation of the training program once the grant project is completed,  
145.4 the extent to which the proposed project is consistent with the goal of increasing access to  
145.5 primary care and mental health services for rural and underserved urban communities, the  
145.6 extent to which the proposed project incorporates team-based primary care, and project  
145.7 costs and use of funds.

145.8 Subd. 5. **Program oversight.** The commissioner shall determine the amount of a grant  
145.9 to be given to an eligible program based on the relative score of each eligible program's  
145.10 application, including rural locations as applicable under subdivision 2, paragraph (b), other  
145.11 relevant factors discussed during the review, and the funds available to the commissioner.  
145.12 Appropriations made to the program do not cancel and are available until expended. During  
145.13 the grant period, the commissioner may require and collect from programs receiving grants  
145.14 any information necessary to evaluate the program.

145.15 Sec. 55. [144.1507] PRIMARY CARE RESIDENCY TRAINING GRANT  
145.16 PROGRAM.

145.17 Subdivision 1. Definitions. (a) For purposes of this section, the following terms have  
145.18 the meanings given.

145.19 (b) "Eligible program" means a program that meets the following criteria:

145.20 (1) is located in Minnesota;

145.21 (2) trains medical residents in the specialties of family medicine, general internal  
145.22 medicine, general pediatrics, psychiatry, geriatrics, or general surgery in rural residency  
145.23 training programs or in community-based ambulatory care centers that primarily serve the  
145.24 underserved; and

145.25 (3) is accredited by the Accreditation Council for Graduate Medical Education or presents  
145.26 a credible plan to obtain accreditation.

145.27 (c) "Rural residency training program" means a residency program that provides an  
145.28 initial year of training in an accredited residency program in Minnesota. The subsequent  
145.29 years of the residency program are based in rural communities, utilizing local clinics and  
145.30 community hospitals, with specialty rotations in nearby regional medical centers.

145.31 (d) "Community-based ambulatory care centers" means federally qualified health centers,  
145.32 community mental health centers, rural health clinics, health centers operated by the Indian

146.1 Health Service, an Indian Tribe or Tribal organization, or an urban American Indian  
146.2 organization or an entity receiving funds under Title X of the Public Health Service Act.

146.3 (e) "Eligible project" means a project to establish and maintain a rural residency training  
146.4 program.

146.5 Subd. 2. **Rural residency training program.** (a) The commissioner of health shall  
146.6 award rural residency training program grants to eligible programs to plan, implement, and  
146.7 sustain rural residency training programs. A rural residency training program grant shall  
146.8 not exceed \$250,000 per year for up to three years for planning and development, and  
146.9 \$225,000 per resident per year for each year thereafter to sustain the program.

146.10 (b) Funds may be spent to cover the costs of:

146.11 (1) planning related to establishing accredited rural residency training programs;

146.12 (2) obtaining accreditation by the Accreditation Council for Graduate Medical Education  
146.13 or another national body that accredits rural residency training programs;

146.14 (3) establishing new rural residency training programs;

146.15 (4) recruitment, training, and retention of new residents and faculty related to the new  
146.16 rural residency training program;

146.17 (5) travel and lodging for new residents;

146.18 (6) faculty, new resident, and preceptor salaries related to new rural residency training  
146.19 programs;

146.20 (7) training site improvements, fees, equipment, and supplies required for new rural  
146.21 residency training programs; and

146.22 (8) supporting clinical education in which trainees are part of a primary care team model.

146.23 Subd. 3. **Applications for rural residency training program grants.** Eligible programs  
146.24 seeking a grant shall apply to the commissioner. Applications must include the number of  
146.25 new primary care rural residency training program slots planned, under development or  
146.26 under contract; a description of the training program, including location of the established  
146.27 residency program and rural training sites; a description of the project, including all costs  
146.28 associated with the project; all sources of funds for the project; detailed uses of all funds  
146.29 for the project; the results expected; proof of eligibility for federal graduate medical education  
146.30 funding, if applicable; and a plan to seek the funding. The applicant must describe achievable  
146.31 objectives, a timetable, and the roles and capabilities of responsible individuals in the  
146.32 organization.

147.1 Subd. 4. **Consideration of grant applications.** The commissioner shall review each  
147.2 application to determine if the residency program application is complete, if the proposed  
147.3 rural residency program and residency slots are eligible for a grant, and if the program is  
147.4 eligible for federal graduate medical education funding, and when the funding is available.  
147.5 If eligible programs are not eligible for federal graduate medical education funding, the  
147.6 commissioner may award continuation funding to the eligible program beyond the initial  
147.7 grant period. The commissioner shall award grants to support training programs in family  
147.8 medicine, general internal medicine, general pediatrics, psychiatry, geriatrics, general  
147.9 surgery, and other primary care focus areas.

147.10 Subd. 5. **Program oversight.** During the grant period, the commissioner may require  
147.11 and collect from grantees any information necessary to evaluate the program. Notwithstanding  
147.12 section 16A.28, subdivision 6, encumbrances for grants under this section issued by June  
147.13 30 of each year may be certified for a period of up to three years beyond the year in which  
147.14 the funds were originally appropriated.

147.15 Sec. 56. **[144.1508] CLINICAL HEALTH CARE TRAINING.**

147.16 Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have  
147.17 the meanings given.

147.18 (b) "Accredited clinical training" means the clinical training provided by a medical  
147.19 education program that is accredited through an organization recognized by the Department  
147.20 of Education, the Centers for Medicare and Medicaid Services, or another national body  
147.21 that reviews the accrediting organizations for multiple disciplines and whose standards for  
147.22 recognizing accrediting organizations are reviewed and approved by the commissioner of  
147.23 health.

147.24 (c) "Clinical medical education program" means the accredited clinical training of  
147.25 physicians, medical students, residents, doctors of pharmacy practitioners, doctors of  
147.26 chiropractic, dentists, advanced practice nurses, clinical nurse specialists, certified registered  
147.27 nurse anesthetists, nurse practitioners, certified nurse midwives, physician assistants, dental  
147.28 therapists and advanced dental therapists, psychologists, clinical social workers, community  
147.29 paramedics, community health workers, and other medical professions as determined by  
147.30 the commissioner.

147.31 (d) "Commissioner" means the commissioner of health.

147.32 (e) "Eligible entity" means an organization that is located in Minnesota, provides a  
147.33 clinical medical education experience, and hosts students, residents, or other trainee types

148.1 as determined by the commissioner, and is from an accredited Minnesota teaching program  
148.2 and institution.

148.3 (f) "Eligible trainee FTEs" means the number of trainees, as measured by full-time  
148.4 equivalent counts, that are training in Minnesota at an entity with either currently active  
148.5 medical assistance enrollment status and a National Provider Identification (NPI) number  
148.6 or documentation that they provide sliding fee services. Training may occur in an inpatient  
148.7 or ambulatory patient care setting or alternative setting as determined by the commissioner.  
148.8 Training that occurs in nursing facility settings is not eligible for funding under this section.

148.9 (g) "Teaching institution" means a hospital, medical center, clinic, or other organization  
148.10 that conducts a clinical medical education program in Minnesota that is accountable to the  
148.11 accrediting body.

148.12 (h) "Trainee" means a student, resident, fellow, or other postgraduate involved in a  
148.13 clinical medical education program from an accredited Minnesota teaching program and  
148.14 institution.

148.15 Subd. 2. **Application process.** (a) An eligible entity hosting clinical trainees from a  
148.16 clinical medical education program and teaching institution is eligible for funds under  
148.17 subdivision 3, if the entity:

148.18 (1) is funded in part by sliding fee scale services or enrolled in the Minnesota health  
148.19 care program;

148.20 (2) faces increased financial pressure as a result of competition with nonteaching patient  
148.21 care entities; and

148.22 (3) emphasizes primary care or specialties that are in undersupply in rural or underserved  
148.23 areas of Minnesota.

148.24 (b) An entity hosting a clinical medical education program for advanced practice nursing  
148.25 is eligible for funds under subdivision 3, if the program meets the eligibility requirements  
148.26 in paragraph (a), clauses (1) to (3), and is sponsored by the University of Minnesota  
148.27 Academic Health Center, the Mayo Foundation, or an institution that is part of the Minnesota  
148.28 State Colleges and Universities system or members of the Minnesota Private College Council.

148.29 (c) An application must be submitted to the commissioner by an eligible entity through  
148.30 the teaching institution and contain the following information:

148.31 (1) the official name and address and the site addresses of the clinical medical education  
148.32 programs where eligible trainees are hosted;

149.1 (2) the name, title, and business address of those persons responsible for administering  
149.2 the funds;

149.3 (3) for each applicant, the type and specialty orientation of trainees in the program; the  
149.4 name, entity address, medical assistance provider number, and national provider identification  
149.5 number of each training site used in the program, as appropriate; the federal tax identification  
149.6 number of each training site, where available; the total number of eligible trainee FTEs at  
149.7 each site; and

149.8 (4) other supporting information the commissioner deems necessary.

149.9 (d) An applicant that does not provide information requested by the commissioner shall  
149.10 not be eligible for funds for the current funding cycle.

149.11 Subd. 3. **Distribution of funds.** (a) The commissioner may distribute funds for clinical  
149.12 training in areas of Minnesota and for the professions listed in subdivision 1, paragraph (c),  
149.13 determined by the commissioner as a high need area and profession shortage area. The  
149.14 commissioner shall annually distribute medical education funds to qualifying applicants  
149.15 under this section based on the costs to train, service level needs, and profession or training  
149.16 site shortages. Use of funds is limited to related clinical training costs for eligible programs.

149.17 (b) To ensure the quality of clinical training, eligible entities must demonstrate that they  
149.18 hold contracts in good standing with eligible educational institutions that specify the terms,  
149.19 expectations, and outcomes of the clinical training conducted at sites. Funds shall be  
149.20 distributed in an administrative process determined by the commissioner to be efficient.

149.21 Subd. 4. **Report.** (a) Teaching institutions receiving funds under this section must sign  
149.22 and submit a medical education grant verification report (GVR) to verify funding was  
149.23 distributed as specified in the GVR. If the teaching institution fails to submit the GVR by  
149.24 the stated deadline, the teaching institution is required to return the full amount of funds  
149.25 received to the commissioner within 30 days of receiving notice from the commissioner.  
149.26 The commissioner shall distribute returned funds to the appropriate training sites in  
149.27 accordance with the commissioner's approval letter.

149.28 (b) Teaching institutions receiving funds under this section must provide any other  
149.29 information the commissioner deems appropriate to evaluate the effectiveness of the use of  
149.30 funds for medical education.

150.1 Sec. 57. Minnesota Statutes 2022, section 144.2151, is amended to read:

150.2 **144.2151 FETAL DEATH RECORD AND CERTIFICATE OF BIRTH**  
150.3 **RESULTING IN STILLBIRTH.**

150.4 Subdivision 1. **Filing Registration.** A fetal death record of birth for each birth resulting  
150.5 in a stillbirth in this state, on or after August 1, 2005, must be established for which a each  
150.6 fetal death report is required reported and registered under section 144.222, subdivision 1;  
150.7 shall be filed with the state registrar within five days after the birth if the parent or parents  
150.8 of the stillbirth request to have a record of birth resulting in stillbirth prepared.

150.9 Subd. 2. **Information to parents.** The party responsible for filing a fetal death report  
150.10 under section 144.222, subdivision 1, shall advise the parent or parents of a stillbirth:

150.11 (1) that they may request preparation of a record of birth resulting in stillbirth;

150.12 (2) that preparation of the record is optional; and

150.13 (3) how to obtain a certified copy of the record if one is requested and prepared.

150.14 (1) that the parent or parents may choose to provide a full name or provide only a last  
150.15 name for the record;

150.16 (2) that the parent or parents may request a certificate of birth resulting in stillbirth after  
150.17 the fetal death record is established;

150.18 (3) that the parent who gave birth may request an informational copy of the fetal death  
150.19 record; and

150.20 (4) that the parent or parents named on the fetal death record and the party responsible  
150.21 for reporting the fetal death may correct or amend the record to protect the integrity and  
150.22 accuracy of vital records.

150.23 Subd. 3. **Preparation Responsibilities of the state registrar.** ~~(a) Within five days after~~  
150.24 ~~delivery of a stillbirth, the parent or parents of the stillbirth may prepare and file the record~~  
150.25 ~~with the state registrar if the parent or parents of the stillbirth, after being advised as provided~~  
150.26 ~~in subdivision 2, request to have a record of birth resulting in stillbirth prepared.~~

150.27 ~~(b) If the parent or parents of the stillbirth do not choose to provide a full name for the~~  
150.28 ~~stillbirth, the parent or parents may choose to file only a last name.~~

150.29 ~~(c) Either parent of the stillbirth or, if neither parent is available, another person with~~  
150.30 ~~knowledge of the facts of the stillbirth shall attest to the accuracy of the personal data entered~~  
150.31 ~~on the record in time to permit the filing of the record within five days after delivery.~~

151.1 The state registrar shall:

151.2 (1) prescribe the process to:

151.3 (i) register a fetal death;

151.4 (ii) request the certificate of birth resulting in stillbirth; and

151.5 (iii) request the informational copy of a fetal death record;

151.6 (2) prescribe a standardized format for the certificate of birth resulting in stillbirth, which

151.7 shall integrate security features and be as similar as possible to a birth certificate;

151.8 (3) issue a certificate of birth resulting in stillbirth or a statement of no vital record found

151.9 to the parent or parents named on the fetal death record upon the parent's proper completion

151.10 of an attestation provided by the commissioner and payment of the required fee;

151.11 (4) correct or amend the fetal death record upon a request from the parent who gave

151.12 birth, parents, or the person who registered the fetal death or filed the report; and

151.13 (5) refuse to amend or correct the fetal death record when an applicant does not submit

151.14 the minimum documentation required to amend the record or when the state registrar has

151.15 cause to question the validity or completeness of the applicant's statements or any

151.16 documentary evidence and the deficiencies are not corrected. The state registrar shall advise

151.17 the applicant of the reason for this action and shall further advise the applicant of the right

151.18 of appeal to a court with competent jurisdiction over the Department of Health.

151.19 Subd. 4. ~~Retroactive application~~ **Delayed registration.** ~~Notwithstanding subdivisions~~

151.20 ~~1 to 3, If a birth that fetal death occurred in this state at any time resulted in a stillbirth for~~

151.21 ~~which a fetal death report was required under section 144.222, subdivision 1, but a record~~

151.22 ~~of birth resulting in stillbirth was not prepared under subdivision 3, a parent of the stillbirth~~

151.23 ~~may submit to the state registrar, on or after August 1, 2005, a written request for preparation~~

151.24 ~~of a record of birth resulting in stillbirth and evidence of the facts of the stillbirth in the~~

151.25 ~~form and manner specified by the state registrar. The state registrar shall prepare and file~~

151.26 ~~the record of birth resulting in stillbirth within 30 days after receiving satisfactory evidence~~

151.27 ~~of the facts of the stillbirth. fetal death was not registered and a record was not established,~~

151.28 a person responsible for registering the fetal death, the medical examiner or coroner with

151.29 jurisdiction, or a parent may submit to the state registrar a written request to register the

151.30 fetal death and submit the evidence to support the request.

151.31 Subd. 5. ~~Responsibilities of state registrar.~~ The state registrar shall:

152.1 ~~(1) prescribe the form of and information to be included on a record of birth resulting~~  
 152.2 ~~in stillbirth, which shall be as similar as possible to the form of and information included~~  
 152.3 ~~on a record of birth;~~

152.4 ~~(2) prescribe the form of and information to be provided by the parent of a stillbirth~~  
 152.5 ~~requesting a record of birth resulting in stillbirth under subdivisions 3 and 4 and make this~~  
 152.6 ~~form available on the Department of Health's website;~~

152.7 ~~(3) issue a certified copy of a record of birth resulting in stillbirth to a parent of the~~  
 152.8 ~~stillbirth that is the subject of the record if:~~

152.9 ~~(i) a record of birth resulting in stillbirth has been prepared and filed under subdivision~~  
 152.10 ~~3 or 4; and~~

152.11 ~~(ii) the parent requesting a certified copy of the record submits the request in writing;~~  
 152.12 ~~and~~

152.13 ~~(4) create and implement a process for entering, preparing, and handling stillbirth records~~  
 152.14 ~~identical or as close as possible to the processes for birth and fetal death records when~~  
 152.15 ~~feasible, but no later than the date on which the next reprogramming of the Department of~~  
 152.16 ~~Health's database for vital records is completed.~~

152.17 Sec. 58. Minnesota Statutes 2022, section 144.222, is amended to read:

152.18 **144.222 FETAL DEATH REPORTS OF FETAL OR INFANT DEATH AND**  
 152.19 **REGISTRATION.**

152.20 Subdivision 1. **Fetal death report required.** A fetal death ~~report~~ must be filed registered  
 152.21 or reported within five days of the death of a fetus for whom 20 or more weeks of gestation  
 152.22 have elapsed, except for abortions defined under section 145.4241. A fetal death ~~report~~ must  
 152.23 be prepared must be registered or reported in a format prescribed by the state registrar and  
 152.24 filed in accordance with Minnesota Rules, parts 4601.0100 to 4601.2600 by:

152.25 (1) a person in charge of an institution or that person's authorized designee if a fetus is  
 152.26 delivered in the institution or en route to the institution;

152.27 (2) a physician, certified nurse midwife, or other licensed medical personnel in attendance  
 152.28 at or immediately after the delivery if a fetus is delivered outside an institution; or

152.29 (3) a parent or other person in charge of the disposition of the remains if a fetal death  
 152.30 occurred without medical attendance at or immediately after the delivery.

152.31 ~~Subd. 2. **Sudden infant death.** Each infant death which is diagnosed as sudden infant~~  
 152.32 ~~death syndrome shall be reported within five days to the state registrar.~~

153.1 Sec. 59. Minnesota Statutes 2022, section 144.222, subdivision 1, is amended to read:

153.2 Subdivision 1. **Fetal death report required.** A fetal death report must be filed within  
153.3 five days of the death of a fetus for whom 20 or more weeks of gestation have elapsed,  
153.4 except for abortions defined under section ~~145.4241~~ 145.411, subdivision 5. A fetal death  
153.5 report must be prepared in a format prescribed by the state registrar and filed in accordance  
153.6 with Minnesota Rules, parts 4601.0100 to 4601.2600 by:

153.7 (1) a person in charge of an institution or that person's authorized designee if a fetus is  
153.8 delivered in the institution or en route to the institution;

153.9 (2) a physician, certified nurse midwife, or other licensed medical personnel in attendance  
153.10 at or immediately after the delivery if a fetus is delivered outside an institution; or

153.11 (3) a parent or other person in charge of the disposition of the remains if a fetal death  
153.12 occurred without medical attendance at or immediately after the delivery.

153.13 **EFFECTIVE DATE.** This section is effective the day following final enactment.

153.14 Sec. 60. Minnesota Statutes 2022, section 144.226, subdivision 3, is amended to read:

153.15 Subd. 3. **Birth record surcharge.** (a) In addition to any fee prescribed under subdivision  
153.16 1, there shall be a nonrefundable surcharge of \$3 for each certified birth or stillbirth record  
153.17 and for a certification that the vital record cannot be found. The state registrar or local  
153.18 issuance office shall forward this amount to the commissioner of management and budget  
153.19 each month following the collection of the surcharge for deposit into the account for the  
153.20 children's trust fund for the prevention of child abuse established under section 256E.22.  
153.21 This surcharge shall not be charged under those circumstances in which no fee for a certified  
153.22 birth or stillbirth record is permitted under subdivision 1, paragraph (b). Upon certification  
153.23 by the commissioner of management and budget that the assets in that fund exceed  
153.24 \$20,000,000, this surcharge shall be discontinued.

153.25 (b) In addition to any fee prescribed under subdivision 1, there shall be a nonrefundable  
153.26 surcharge of \$10 for each certified birth record. The state registrar or local issuance office  
153.27 shall forward this amount to the commissioner of management and budget each month  
153.28 following the collection of the surcharge for deposit in the general fund.

153.29 Sec. 61. Minnesota Statutes 2022, section 144.226, subdivision 4, is amended to read:

153.30 Subd. 4. **Vital records surcharge.** In addition to any fee prescribed under subdivision  
153.31 1, there is a nonrefundable surcharge of \$4 for each certified and noncertified birth, stillbirth,  
153.32 or death record, and for a certification that the record cannot be found. The local issuance

154.1 office or state registrar shall forward this amount to the commissioner of management and  
154.2 budget each month following the collection of the surcharge to be deposited into the state  
154.3 government special revenue fund.

154.4 Sec. 62. [144.3431] NONRESIDENTIAL MENTAL HEALTH SERVICES.

154.5 A minor who is age 16 or older may give effective consent for nonresidential mental  
154.6 health services, and the consent of no other person is required. For purposes of this section,  
154.7 "nonresidential mental health services" means outpatient services as defined in section  
154.8 245.4871, subdivision 29, provided to a minor who is not residing in a hospital, inpatient  
154.9 unit, or licensed residential treatment facility or program.

154.10 Sec. 63. Minnesota Statutes 2022, section 144.382, is amended by adding a subdivision  
154.11 to read:

154.12 Subd. 2a. **Connector.** "Connector" means gooseneck, pigtail, and other service line  
154.13 connectors. A connector is typically a short section of piping not exceeding two feet that  
154.14 can be bent and used for connections between rigid service piping.

154.15 Sec. 64. Minnesota Statutes 2022, section 144.382, is amended by adding a subdivision  
154.16 to read:

154.17 Subd. 3a. **Galvanized requiring replacement.** "Galvanized requiring replacement"  
154.18 means a galvanized service line that is or was at any time connected to a lead service line  
154.19 or lead status unknown service line, or is currently or was previously affixed to a lead  
154.20 connector. The majority of galvanized service lines fall under this category.

154.21 Sec. 65. Minnesota Statutes 2022, section 144.382, is amended by adding a subdivision  
154.22 to read:

154.23 Subd. 3b. **Galvanized service line.** "Galvanized service line" means a service line made  
154.24 of iron or piping that has been dipped in zinc to prevent corrosion and rusting.

154.25 Sec. 66. Minnesota Statutes 2022, section 144.382, is amended by adding a subdivision  
154.26 to read:

154.27 Subd. 3c. **Lead connector.** "Lead connector" means a connector made of lead.

155.1 Sec. 67. Minnesota Statutes 2022, section 144.382, is amended by adding a subdivision  
155.2 to read:

155.3 Subd. 3d. **Lead service line.** "Lead service line" means a portion of pipe that is made  
155.4 of lead, which connects the water main to the building inlet. A lead service line may be  
155.5 owned by the water system, by the property owner, or both.

155.6 Sec. 68. Minnesota Statutes 2022, section 144.382, is amended by adding a subdivision  
155.7 to read:

155.8 Subd. 3e. **Lead status unknown service line or unknown service line.** "Lead status  
155.9 unknown service line" or "unknown service line" means a service line that has not been  
155.10 demonstrated to meet or does not meet the definition of lead free in section 1417 of the Safe  
155.11 Drinking Water Act.

155.12 Sec. 69. Minnesota Statutes 2022, section 144.382, is amended by adding a subdivision  
155.13 to read:

155.14 Subd. 3f. **Nonlead service line.** "Nonlead service line" means a service line determined  
155.15 through an evidence-based record, method, or technique not to be a lead service line or  
155.16 galvanized service line requiring replacement. Most nonlead service lines are made of copper  
155.17 or plastic.

155.18 Sec. 70. Minnesota Statutes 2022, section 144.382, is amended by adding a subdivision  
155.19 to read:

155.20 Subd. 4a. **Service line.** "Service line" means a portion of pipe that connects the water  
155.21 main to the building inlet. A service line may be owned by the water system, by the property  
155.22 owner, or both. A service line may be made of many materials, such as lead, copper,  
155.23 galvanized steel, or plastic.

155.24 Sec. 71. [144.3853] **CLASSIFICATION OF SERVICE LINES.**

155.25 Subdivision 1. **Classification of lead status of service line.** (a) A water system may  
155.26 classify the actual material of a service line, such as copper or plastic, as an alternative to  
155.27 classifying the service line as a nonlead service line, for the purpose of the lead service line  
155.28 inventory.

155.29 (b) It is not necessary to physically verify the material composition, such as copper or  
155.30 plastic, of a service line for its lead status to be identified. For example, if records demonstrate

156.1 the service line was installed after a municipal, state, or federal ban on the installation of  
156.2 lead service lines, the service line may be classified as a nonlead service line.

156.3 Subd. 2. **Lead connector.** For the purposes of the lead service line inventory and lead  
156.4 service line replacement plan, if a service line has a lead connector, the service line shall  
156.5 be classified as a lead service line or a galvanized service line requiring replacement.

156.6 Subd. 3. **Galvanized service line.** A galvanized service line may only be classified as  
156.7 a nonlead service line if there is documentation verifying it was never connected to a lead  
156.8 service line or lead connector. Rarely will a galvanized service line be considered a nonlead  
156.9 service line.

156.10 Sec. 72. **[144.398] TOBACCO USE PREVENTION ACCOUNT; ESTABLISHMENT**  
156.11 **AND USES.**

156.12 Subdivision 1. **Definitions.** (a) As used in this section, the terms in this subdivision have  
156.13 the meanings given.

156.14 (b) "Electronic delivery device" has the meaning given in section 609.685, subdivision  
156.15 1, paragraph (c).

156.16 (c) "Nicotine delivery product" has the meaning given in section 609.6855, subdivision  
156.17 1, paragraph (c).

156.18 (d) "Tobacco" has the meaning given in section 609.685, subdivision 1, paragraph (a).

156.19 (e) "Tobacco-related devices" has the meaning given in section 609.685, subdivision 1,  
156.20 paragraph (b).

156.21 Subd. 2. **Account created.** A tobacco use prevention account is created in the special  
156.22 revenue fund. Pursuant to section 16A.151, subdivision 2, paragraph (h), the commissioner  
156.23 of management and budget shall deposit into the account any money received by the state  
156.24 resulting from a settlement agreement or an assurance of discontinuance entered into by the  
156.25 attorney general of the state, or a court order in litigation brought by the attorney general  
156.26 of the state on behalf of the state or a state agency related to alleged violations of consumer  
156.27 fraud laws in the marketing, sale, or distribution of electronic nicotine delivery systems in  
156.28 this state or other alleged illegal actions that contributed to the exacerbation of youth nicotine  
156.29 use.

156.30 Subd. 3. **Appropriations from tobacco use prevention account.** (a) Each fiscal year,  
156.31 the amount of money in the tobacco use prevention account is appropriated to the  
156.32 commissioner of health for:

157.1 (1) tobacco and electronic delivery device use prevention and cessation projects consistent  
157.2 with the duties specified in section 144.392;

157.3 (2) a public information program under section 144.393;

157.4 (3) the development of health promotion and health education materials about tobacco  
157.5 and electronic delivery device use prevention and cessation;

157.6 (4) tobacco and electronic delivery device use prevention activities under section 144.396;  
157.7 and

157.8 (5) statewide tobacco cessation services under section 144.397.

157.9 (b) In activities funded under this subdivision, the commissioner of health must:

157.10 (1) prioritize preventing persons under the age of 21 from using commercial tobacco,  
157.11 electronic delivery devices, tobacco-related devices, and nicotine delivery products;

157.12 (2) promote racial and health equity; and

157.13 (3) use strategies that are evidence-based or based on promising practices.

157.14 **EFFECTIVE DATE.** This section is effective the day following final enactment.

157.15 Sec. 73. Minnesota Statutes 2022, section 144.55, subdivision 3, is amended to read:

157.16 Subd. 3. **Standards for licensure.** (a) Notwithstanding the provisions of section 144.56,  
157.17 for the purpose of hospital licensure, the commissioner of health shall use as minimum  
157.18 standards the hospital certification regulations promulgated pursuant to title XVIII of the  
157.19 Social Security Act, United States Code, title 42, section 1395, et seq. The commissioner  
157.20 may use as minimum standards changes in the federal hospital certification regulations  
157.21 promulgated after May 7, 1981, if the commissioner finds that such changes are reasonably  
157.22 necessary to protect public health and safety. ~~The commissioner shall also promulgate in~~  
157.23 ~~rules additional minimum standards for new construction.~~

157.24 (b) Hospitals must meet the applicable provisions of the 2022 edition of the Facility  
157.25 Guidelines Institute *Guidelines for Design and Construction of Hospitals*. This minimum  
157.26 design standard must be met for all new licenses, new construction, change of use, or change  
157.27 of occupancy for which plan review packages are received on or after January 1, 2024.

157.28 (c) If the commissioner decides to update the edition of the guidelines specified in  
157.29 paragraph (b) for purposes of this subdivision, the commissioner must notify the chairs and  
157.30 ranking minority members of the legislative committees with jurisdiction over health care  
157.31 and public safety of the planned update by January 15 of the year in which the new edition

158.1 will become effective. Following notice from the commissioner, the new edition shall  
158.2 become effective for hospitals beginning August 1 of that year, unless otherwise provided  
158.3 in law. The commissioner shall, by publication in the State Register, specify a date by which  
158.4 hospitals must comply with the updated edition. The date by which hospitals must comply  
158.5 shall not be sooner than 12 months after publication of the commissioner's notice in the  
158.6 State Register and shall apply only to plan review packages received on or after that date.

158.7 (d) Hospitals shall be in compliance with all applicable state and local governing laws,  
158.8 regulations, standards, ordinances, and codes for fire safety, building, and zoning  
158.9 requirements.

158.10 ~~(b)~~ (e) Each hospital and outpatient surgical center shall establish policies and procedures  
158.11 to prevent the transmission of human immunodeficiency virus and hepatitis B virus to  
158.12 patients and within the health care setting. The policies and procedures shall be developed  
158.13 in conformance with the most recent recommendations issued by the United States  
158.14 Department of Health and Human Services, Public Health Service, Centers for Disease  
158.15 Control. The commissioner of health shall evaluate a hospital's compliance with the policies  
158.16 and procedures according to subdivision 4.

158.17 ~~(e)~~ (f) An outpatient surgical center must establish and maintain a comprehensive  
158.18 tuberculosis infection control program according to the most current tuberculosis infection  
158.19 control guidelines issued by the United States Centers for Disease Control and Prevention  
158.20 (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality  
158.21 Weekly Report (MMWR). This program must include a tuberculosis infection control plan  
158.22 that covers all paid and unpaid employees, contractors, students, and volunteers. The  
158.23 Department of Health shall provide technical assistance regarding implementation of the  
158.24 guidelines.

158.25 ~~(d)~~ (g) Written compliance with this subdivision must be maintained by the outpatient  
158.26 surgical center.

158.27 **EFFECTIVE DATE.** This section is effective January 1, 2024.

158.28 Sec. 74. Minnesota Statutes 2022, section 144.566, is amended to read:

158.29 **144.566 VIOLENCE AGAINST HEALTH CARE WORKERS.**

158.30 Subdivision 1. **Definitions.** (a) The following definitions apply to this section and have  
158.31 the meanings given.

159.1 (b) "Act of violence" means an act by a patient or visitor against a health care worker  
159.2 that includes kicking, scratching, urinating, sexually harassing, or any act defined in sections  
159.3 609.221 to 609.2241.

159.4 (c) "Commissioner" means the commissioner of health.

159.5 (d) "Health care worker" means any person, whether licensed or unlicensed, employed  
159.6 by, volunteering in, or under contract with a hospital, who has direct contact with a patient  
159.7 of the hospital for purposes of either medical care or emergency response to situations  
159.8 potentially involving violence.

159.9 (e) "Hospital" means any facility licensed as a hospital under section 144.55.

159.10 (f) "Incident response" means the actions taken by hospital administration and health  
159.11 care workers during and following an act of violence.

159.12 (g) "Interfere" means to prevent, impede, discourage, or delay a health care worker's  
159.13 ability to report acts of violence, including by retaliating or threatening to retaliate against  
159.14 a health care worker.

159.15 (h) "Preparedness" means the actions taken by hospital administration and health care  
159.16 workers to prevent a single act of violence or acts of violence generally.

159.17 (i) "Retaliate" means to discharge, discipline, threaten, otherwise discriminate against,  
159.18 or penalize a health care worker regarding the health care worker's compensation, terms,  
159.19 conditions, location, or privileges of employment.

159.20 (j) "Workplace violence hazards" means locations and situations where violent incidents  
159.21 are more likely to occur, including, as applicable, but not limited to locations isolated from  
159.22 other health care workers; health care workers working alone; health care workers working  
159.23 in remote locations; health care workers working late night or early morning hours; locations  
159.24 where an assailant could prevent entry of responders or other health care workers into a  
159.25 work area; locations with poor illumination; locations with poor visibility; lack of physical  
159.26 barriers between health care workers and persons at risk of committing workplace violence;  
159.27 lack of effective escape routes; obstacles and impediments to accessing alarm systems;  
159.28 locations within the facility where alarm systems are not operational; entryways where  
159.29 unauthorized entrance may occur, such as doors designated for staff entrance or emergency  
159.30 exits; presence, in the areas where patient contact activities are performed, of furnishings  
159.31 or objects that could be used as weapons; and locations where high-value items, currency,  
159.32 or pharmaceuticals are stored.

160.1 Subd. 2. ~~Hospital duties~~ **Action plans and action plan reviews required.** (a) All  
160.2 hospitals must design and implement preparedness and incident response action plans to  
160.3 acts of violence by January 15, 2016, and review and update the plan at least annually  
160.4 thereafter. The plan must be in writing; specific to the workplace violence hazards and  
160.5 corrective measures for the units, services, or operations of the hospital; and available to  
160.6 health care workers at all times.

160.7 Subd. 3. **Action plan committees.** (b) A hospital shall designate a committee of  
160.8 representatives of health care workers employed by the hospital, including nonmanagerial  
160.9 health care workers, nonclinical staff, administrators, patient safety experts, and other  
160.10 appropriate personnel to develop preparedness and incident response action plans to acts  
160.11 of violence. The hospital shall, in consultation with the designated committee, implement  
160.12 the plans under ~~paragraph (a)~~ subdivision 2. Nothing in this ~~paragraph~~ subdivision shall  
160.13 require the establishment of a separate committee solely for the purpose required by this  
160.14 subdivision.

160.15 Subd. 4. **Required elements of action plans; generally.** The preparedness and incident  
160.16 response action plans to acts of violence must include:

160.17 (1) effective procedures to obtain the active involvement of health care workers and  
160.18 their representatives in developing, implementing, and reviewing the plan, including their  
160.19 participation in identifying, evaluating, and correcting workplace violence hazards, designing  
160.20 and implementing training, and reporting and investigating incidents of workplace violence;

160.21 (2) names or job titles of the persons responsible for implementing the plan; and

160.22 (3) effective procedures to ensure that supervisory and nonsupervisory health care  
160.23 workers comply with the plan.

160.24 Subd. 5. **Required elements of action plans; evaluation of risk factors.** (a) The  
160.25 preparedness and incident response action plans to acts of violence must include assessment  
160.26 procedures to identify and evaluate workplace violence hazards for each facility, unit,  
160.27 service, or operation, including community-based risk factors and areas surrounding the  
160.28 facility, such as employee parking areas and other outdoor areas. Procedures shall specify  
160.29 the frequency with which such environmental assessments will take place.

160.30 (b) The preparedness and incident response action plans to acts of violence must include  
160.31 assessment tools, environmental checklists, or other effective means to identify workplace  
160.32 violence hazards.

161.1 **Subd. 6. Required elements of action plans; review of workplace violence**

161.2 **incidents.** The preparedness and incident response action plans to acts of violence must  
161.3 include procedures for reviewing all workplace violence incidents that occurred in the  
161.4 facility, unit, service, or operation within the previous year, whether or not an injury occurred.

161.5 **Subd. 7. Required elements of action plans; reporting workplace violence.** The  
161.6 preparedness and incident response action plans to acts of violence must include:

161.7 (1) effective procedures for health care workers to document information regarding  
161.8 conditions that may increase the potential for workplace violence incidents and communicate  
161.9 that information without fear of reprisal to other health care workers, shifts, or units;

161.10 (2) effective procedures for health care workers to report a violent incident, threat, or  
161.11 other workplace violence concern without fear of reprisal;

161.12 (3) effective procedures for the hospital to accept and respond to reports of workplace  
161.13 violence and to prohibit retaliation against a health care worker who makes such a report;

161.14 (4) a policy statement stating the hospital will not prevent a health care worker from  
161.15 reporting workplace violence or take punitive or retaliatory action against a health care  
161.16 worker for doing so;

161.17 (5) effective procedures for investigating health care worker concerns regarding workplace  
161.18 violence or workplace violence hazards;

161.19 (6) procedures for informing health care workers of the results of the investigation arising  
161.20 from a report of workplace violence or from a concern about a workplace violence hazard  
161.21 and of any corrective actions taken;

161.22 (7) effective procedures for obtaining assistance from the appropriate law enforcement  
161.23 agency or social service agency during all work shifts. The procedure may establish a central  
161.24 coordination procedure; and

161.25 (8) a policy statement stating the hospital will not prevent a health care worker from  
161.26 seeking assistance and intervention from local emergency services or law enforcement when  
161.27 a violent incident occurs or take punitive or retaliatory action against a health care worker  
161.28 for doing so.

161.29 **Subd. 8. Required elements of action plans; coordination with other employers.** The  
161.30 preparedness and incident response action plans to acts of violence must include methods  
161.31 the hospital will use to coordinate implementation of the plan with other employers whose  
161.32 employees work in the same health care facility, unit, service, or operation and to ensure  
161.33 that those employers and their employees understand their respective roles as provided in

162.1 the plan. These methods must ensure that all employees working in the facility, unit, service,  
162.2 or operation are provided the training required by subdivision 11 and that workplace violence  
162.3 incidents involving any employee are reported, investigated, and recorded.

162.4 **Subd. 9. Required elements of action plans; white supremacist affiliation and support**  
162.5 **prohibited.** (a) The preparedness and incident response action plans to acts of violence  
162.6 must include a policy statement stating that security personnel employed by the hospital or  
162.7 assigned to the hospital by a contractor are prohibited from affiliating with, supporting, or  
162.8 advocating for white supremacist groups, causes, or ideologies or participating in, or actively  
162.9 promoting, an international or domestic extremist group that the Federal Bureau of  
162.10 Investigation has determined supports or encourages illegal, violent conduct.

162.11 (b) For purposes of this subdivision, white supremacist groups, causes, or ideologies  
162.12 include organizations and associations and ideologies that promote white supremacy and  
162.13 the idea that white people are superior to Black, Indigenous, and people of color (BIPOC);  
162.14 promote religious and racial bigotry; seek to exacerbate racial and ethnic tensions between  
162.15 BIPOC and non-BIPOC; or engage in patently hateful and inflammatory speech, intimidation,  
162.16 and violence against BIPOC as means of promoting white supremacy.

162.17 **Subd. 10. Required elements of action plans; training.** (a) The preparedness and  
162.18 incident response action plans to acts of violence must include:

162.19 (1) procedures for developing and providing the training required in subdivision 11 that  
162.20 permits health care workers and their representatives to participate in developing the training;  
162.21 and

162.22 (2) a requirement for cultural competency training and equity, diversity, and inclusion  
162.23 training.

162.24 (b) The preparedness and incident response action plans to acts of violence must include  
162.25 procedures to communicate with health care workers regarding workplace violence matters,  
162.26 including:

162.27 (1) how health care workers will document and communicate to other health care workers  
162.28 and between shifts and units information regarding conditions that may increase the potential  
162.29 for workplace violence incidents;

162.30 (2) how health care workers can report a violent incident, threat, or other workplace  
162.31 violence concern;

162.32 (3) how health care workers can communicate workplace violence concerns without  
162.33 fear of reprisal; and

163.1 (4) how health care worker concerns will be investigated, and how health care workers  
163.2 will be informed of the results of the investigation and any corrective actions to be taken.

163.3 Subd. 11. **Training required.** ~~(e)~~ A hospital ~~shall~~ must provide training to all health  
163.4 care workers employed or contracted with the hospital on safety during acts of violence.  
163.5 Each health care worker must receive safety training ~~annually and upon hire~~ during the  
163.6 health care worker's orientation and before the health care worker completes a shift  
163.7 independently, and annually thereafter. Training must, at a minimum, include:

163.8 (1) safety guidelines for response to and de-escalation of an act of violence;

163.9 (2) ways to identify potentially violent or abusive situations, including aggression and  
163.10 violence predicting factors; and

163.11 (3) the hospital's ~~incident response reaction plan and violence prevention plan~~  
163.12 preparedness and incident response action plans for acts of violence, including how the  
163.13 health care worker may report concerns about workplace violence within each hospital's  
163.14 reporting structure without fear of reprisal, how the hospital will address workplace violence  
163.15 incidents, and how the health care worker can participate in reviewing and revising the plan;  
163.16 and

163.17 (4) any resources available to health care workers for coping with incidents of violence,  
163.18 including but not limited to critical incident stress debriefing or employee assistance  
163.19 programs.

163.20 Subd. 12. **Annual review and update of action plans.** ~~(d)~~ (a) As part of its annual  
163.21 review of preparedness and incident response action plans required under paragraph (a)  
163.22 subdivision 2, the hospital must review with the designated committee:

163.23 (1) the effectiveness of its preparedness and incident response action plans, including  
163.24 the sufficiency of security systems, alarms, emergency responses, and security personnel  
163.25 availability;

163.26 (2) security risks associated with specific units, areas of the facility with uncontrolled  
163.27 access, late night shifts, early morning shifts, and areas surrounding the facility such as  
163.28 employee parking areas and other outdoor areas;

163.29 (3) the most recent gap analysis as provided by the commissioner; and

163.30 ~~(3)~~ (4) the number of acts of violence that occurred in the hospital during the previous  
163.31 year, including injuries sustained, if any, and the unit in which the incident occurred;

164.1 (5) evaluations of staffing, including staffing patterns and patient classification systems  
164.2 that contribute to, or are insufficient to address, the risk of violence; and

164.3 (6) any reports of discrimination or abuse that arise from security resources, including  
164.4 from the behavior of security personnel.

164.5 (b) As part of the annual update of preparedness and incident response action plans  
164.6 required under subdivision 2, the hospital must incorporate corrective actions into the action  
164.7 plan to address workplace violence hazards identified during the annual action plan review,  
164.8 reports of workplace violence, reports of workplace violence hazards, and reports of  
164.9 discrimination or abuse that arise from the security resources.

164.10 Subd. 13. **Action plan updates.** Following the annual review of the action plan, a hospital  
164.11 must update the action plans to reflect the corrective actions the hospital will implement to  
164.12 mitigate the hazards and vulnerabilities identified during the annual review.

164.13 Subd. 14. **Requests for additional staffing.** A hospital shall create and implement a  
164.14 procedure for a health care worker to officially request of hospital supervisors or  
164.15 administration that additional staffing be provided. The hospital must document all requests  
164.16 for additional staffing made because of a health care worker's concern over a risk of an act  
164.17 of violence. If the request for additional staffing to reduce the risk of violence is denied,  
164.18 the hospital must provide the health care worker who made the request a written reason for  
164.19 the denial and must maintain documentation of that communication with the documentation  
164.20 of requests for additional staffing. A hospital must make documentation regarding staffing  
164.21 requests available to the commissioner for inspection at the commissioner's request. The  
164.22 commissioner may use documentation regarding staffing requests to inform the  
164.23 commissioner's determination on whether the hospital is providing adequate staffing and  
164.24 security to address acts of violence, and may use documentation regarding staffing requests  
164.25 if the commissioner imposes a penalty under subdivision 18.

164.26 Subd. 15. **Disclosure of action plans.** ~~(e)~~ (a) A hospital ~~shall~~ must make its most recent  
164.27 action plans and the information listed in paragraph (d) most recent action plan reviews  
164.28 available to ~~local law enforcement~~ all direct care staff and, if any of its workers are  
164.29 represented by a collective bargaining unit, to the exclusive bargaining representatives of  
164.30 those collective bargaining units.

164.31 (b) A hospital must also annually submit to the commissioner its most recent action plan  
164.32 and the results of the most recent annual review conducted under subdivision 12.

164.33 Subd. 16. **Legislative report required.** (a) The commissioner must compile the  
164.34 information into a single annual report and submit the report to the chairs and ranking

165.1 minority members of the legislative committees with jurisdiction over health care by January  
165.2 15 of each year.

165.3 (b) This subdivision does not expire.

165.4 Subd. 17. **Interference prohibited.** (f) A hospital, including any individual, partner,  
165.5 association, or any person or group of persons acting directly or indirectly in the interest of  
165.6 the hospital, ~~shall~~ must not interfere with or discourage a health care worker if the health  
165.7 care worker wishes to contact law enforcement or the commissioner regarding an act of  
165.8 violence.

165.9 Subd. 18. **Penalties.** (g) Notwithstanding section 144.653, subdivision 6, the  
165.10 commissioner may impose ~~an administrative~~ a fine of up to \$250 \$10,000 for failure to  
165.11 comply with the requirements of this ~~subdivision~~ section. The commissioner must allow  
165.12 the hospital at least 30 calendar days to correct a violation of this section before assessing  
165.13 a fine.

165.14 Sec. 75. **[144.587] REQUIREMENTS FOR SCREENING FOR ELIGIBILITY FOR**  
165.15 **HEALTH COVERAGE OR ASSISTANCE.**

165.16 Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section  
165.17 and sections 144.588 to 144.589.

165.18 (b) "Charity care" means the provision of free or discounted care to a patient according  
165.19 to a hospital's financial assistance policies.

165.20 (c) "Hospital" means a private, nonprofit, or municipal hospital licensed under sections  
165.21 144.50 to 144.56.

165.22 (d) "Minnesota attorney general/hospital agreement" means the agreement between the  
165.23 attorney general and certain Minnesota hospitals that is filed in Ramsey County District  
165.24 Court and that establishes requirements for hospital litigation practices, garnishments, use  
165.25 of collection agencies, central billing office practices, and practices for billing uninsured  
165.26 patients.

165.27 (e) "Most favored insurer" means the nongovernmental third-party payor that provided  
165.28 the most revenue to the provider during the previous calendar year.

165.29 (f) "Navigator" has the meaning given in section 62V.02, subdivision 9.

165.30 (g) "Premium tax credit" means a tax credit or premium subsidy under the federal Patient  
165.31 Protection and Affordable Care Act, Public Law 111-148, as amended, including the federal

166.1 Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any  
166.2 amendments to and federal guidance and regulations issued under these acts.

166.3 (h) "Presumptive eligibility" has the meaning given in section 256B.057, subdivision  
166.4 12.

166.5 (i) "Revenue recapture" means the use of the procedures in chapter 270A to collect debt.

166.6 (j) "Uninsured service or treatment" means any service or treatment that is not covered  
166.7 by: (1) a health plan, contract, or policy that provides health coverage to a patient; or (2)  
166.8 any other type of insurance coverage, including but not limited to no-fault automobile  
166.9 coverage, workers' compensation coverage, or liability coverage.

166.10 (k) "Unreasonable burden" includes requiring a patient to apply for enrollment in a state  
166.11 or federal program for which the patient is obviously or categorically ineligible or has been  
166.12 found to be ineligible in the previous 12 months.

166.13 Subd. 2. **Screening.** A hospital must screen a patient who is uninsured or whose insurance  
166.14 coverage status is not known by the hospital for: eligibility for charity care from the hospital;  
166.15 eligibility for state or federal public health care programs using presumptive eligibility or  
166.16 another similar process; and eligibility for a premium tax credit. The hospital must attempt  
166.17 to complete this screening process in person or by telephone within 30 days after the patient  
166.18 receives services at the hospital or at the emergency department associated with the hospital.

166.19 Subd. 3. **Charity care.** (a) Upon completion of the screening process in subdivision 2,  
166.20 the hospital must either assist the patient with applying for charity care and refer the patient  
166.21 to the appropriate department in the hospital for follow-up or make a determination that the  
166.22 patient is ineligible for charity care. A hospital may initiate one or more of the following  
166.23 steps only after the hospital determines that the patient is ineligible for charity care and may  
166.24 not initiate any of the following steps while the patient's application for charity care is  
166.25 pending:

166.26 (1) offering to enroll or enrolling the patient in a payment plan;

166.27 (2) changing the terms of a patient's payment plan;

166.28 (3) offering the patient a loan or line of credit, application materials for a loan or line of  
166.29 credit, or assistance with applying for a loan or line of credit, for the payment of medical  
166.30 debt;

166.31 (4) referring a patient's debt for collections, including in-house collections, third-party  
166.32 collections, revenue recapture, or any other process for the collection of debt;

167.1 (5) denying health care services to the patient or any member of the patient's household  
167.2 because of outstanding medical debt, regardless of whether the services are deemed necessary  
167.3 or may be available from another provider; or

167.4 (6) accepting a credit card payment of over \$500 for the medical debt owed to the hospital.

167.5 (b) A hospital may not impose application procedures for charity care that place an  
167.6 unreasonable burden on the individual patient, taking into account the individual patient's  
167.7 physical, mental, intellectual, or sensory deficiencies or language barriers that may hinder  
167.8 the patient's ability to comply with application procedures.

167.9 (c) When a hospital evaluates a patient's eligibility for charity care, hospital requests to  
167.10 the responsible party for verification of assets or income shall be limited to:

167.11 (1) information that is reasonably necessary and readily available to determine eligibility;  
167.12 and

167.13 (2) facts that are relevant to determine eligibility.

167.14 A hospital must not demand duplicate forms of verification of assets.

167.15 Subd. 4. **Public health care program; premium tax credit.** (a) If a patient is  
167.16 presumptively eligible for a public health care program, the hospital must assist the patient  
167.17 in completing an insurance affordability program application, help the patient schedule an  
167.18 appointment with a navigator organization, or provide the patient with contact information  
167.19 for the nearest available navigator or certified application counselor services.

167.20 (b) If a patient is eligible for a premium tax credit, the hospital may schedule an  
167.21 appointment for the patient with a navigator or a MNsure-certified insurance broker  
167.22 organization or provide the patient with contact information for the nearest available navigator  
167.23 services or a MNsure-certified insurance broker.

167.24 Subd. 5. **Patient may decline services.** A patient may decline to participate in the  
167.25 screening process, to apply for charity care, to complete an insurance affordability program  
167.26 application, to schedule an appointment with a navigator organization, or to accept  
167.27 information about navigator services.

167.28 Subd. 6. **Notice.** (a) A hospital must post notice of the availability of charity care from  
167.29 the hospital in at least the following locations: (1) areas of the hospital where patients are  
167.30 admitted or registered; (2) emergency departments; and (3) the portion of the hospital's  
167.31 financial services or billing department that is accessible to patients. The posted notice must  
167.32 be in all languages spoken by more than five percent of the population in the hospital's  
167.33 service area.

168.1 (b) A hospital must make available on the hospital's website, the current version of the  
168.2 hospital's charity care policy, a plain-language summary of the policy, and the hospital's  
168.3 charity care application form. The summary and application form must be available in all  
168.4 languages spoken by more than five percent of the population in the hospital's service area.

168.5 **EFFECTIVE DATE.** This section is effective November 1, 2023.

168.6 **Sec. 76. [144.588] CERTIFICATION OF EXPERT REVIEW.**

168.7 Subdivision 1. **Requirement; referral to third-party debt collection agency.** (a) In  
168.8 order to refer a patient's account to a third-party debt collection agency, a hospital must  
168.9 complete an affidavit of expert review certifying that the hospital:

168.10 (1) confirmed the information required of the hospital in the most recent version of the  
168.11 Minnesota attorney general/hospital agreement for referral of a specific patient's account  
168.12 to a third-party debt collection agency; and

168.13 (2) unless the patient declined to participate, complied with the requirements in section  
168.14 144.587 to conduct a patient screening and, as applicable, assist the patient in applying for  
168.15 charity care, assist the patient with completing an insurance affordability program application,  
168.16 or refer the patient to a navigator organization.

168.17 (b) The affidavit of expert review must be completed by a designated employee of the  
168.18 hospital seeking to refer the patient's account to a third-party debt collection agency.

168.19 Subd. 2. **Penalty for noncompliance.** Failure to comply with subdivision 1 shall subject  
168.20 a hospital to a fine assessed by the commissioner of health.

168.21 **EFFECTIVE DATE.** This section is effective November 1, 2023.

168.22 **Sec. 77. [144.589] BILLING OF UNINSURED PATIENTS.**

168.23 A hospital shall not charge a patient whose annual household income is less than \$125,000  
168.24 for any uninsured service or treatment in an amount that exceeds the total amount the  
168.25 provider would be reimbursed for that service or treatment from its most favored insurer.  
168.26 The total amount the provider would be reimbursed for that service or treatment from its  
168.27 most favored insurer includes both the amount the provider would be reimbursed directly  
168.28 from its most favored insurer, and the amount the provider would be reimbursed from the  
168.29 insured's policyholder under any applicable co-payments, deductibles, and coinsurance.

168.30 **EFFECTIVE DATE.** This section is effective November 1, 2023.

169.1 Sec. 78. [144.593] REQUIREMENTS FOR CERTAIN HEALTH CARE ENTITY  
169.2 TRANSACTIONS.

169.3 Subdivision 1. Definitions. (a) For purposes of this section, the following terms have  
169.4 the meaning given.

169.5 (b) "Captive professional entity" means a professional corporation, limited liability  
169.6 company, or other entity formed to render professional services in which a beneficial owner  
169.7 is a health care provider employed by, controlled by, or subject to the direction of a hospital  
169.8 or hospital system.

169.9 (c) "Commissioner" means the commissioner of health.

169.10 (d) "Health care entity" means:

169.11 (1) a hospital;

169.12 (2) a hospital system;

169.13 (3) a captive professional entity;

169.14 (4) a medical foundation;

169.15 (5) a health care provider group practice;

169.16 (6) an entity organized or controlled by an entity listed in clauses (1) to (5); or

169.17 (7) an entity that owns or exercised substantial control over an entity listed in clauses  
169.18 (1) to (5).

169.19 (e) "Health care provider" means a physician licensed under chapter 147, a physician  
169.20 assistant licensed under chapter 147A, or an advanced practice registered nurse as defined  
169.21 in section 148.171, subdivision 3, who provides health care services, including but not  
169.22 limited to medical care, consultation, diagnosis, or treatment.

169.23 (f) "Health care provider group practice" means two or more health care providers legally  
169.24 organized in a partnership, professional corporation, limited liability company, medical  
169.25 foundation, nonprofit corporation, faculty practice plan, or other similar entity:

169.26 (1) in which each health care provider who is a member of the group provides  
169.27 substantially the full range of services that a health care provider routinely provides, including  
169.28 but not limited to medical care, consultation, diagnosis, and treatment, through the joint use  
169.29 of shared office space, facilities, equipment, or personnel;

170.1 (2) for which substantially all services of the health care providers who are group  
170.2 members are provided through the group and are billed in the name of the group practice  
170.3 and amounts so received are treated as receipts of the group; or

170.4 (3) in which the overhead expenses of, and the income from, the group are distributed  
170.5 in accordance with methods previously determined by members of the group.

170.6 An entity that otherwise meets the definition of health care provider group practice in this  
170.7 paragraph shall be considered a health care provider group practice even if its shareholders,  
170.8 partners, or owners include single-health care provider professional corporations, limited  
170.9 liability companies formed to render professional services, or other entities in which  
170.10 beneficial owners are individual health care providers.

170.11 (g) "Hospital" means a health care facility licensed as a hospital under sections 144.50  
170.12 to 144.56.

170.13 (h) "Medical foundation" means a nonprofit legal entity through which physicians or  
170.14 other health care providers perform research or provide medical services.

170.15 (i) "Transaction" means a single action, or a series of actions within a five-year period,  
170.16 that constitutes:

170.17 (1) a merger or exchange of a health care entity with another entity;

170.18 (2) the sale, lease, or transfer of 30 percent or more of the assets of a health care entity  
170.19 to another entity;

170.20 (3) the granting of a security interest of 30 percent or more of the property and assets  
170.21 of a health care entity to another entity;

170.22 (4) the transfer of 30 percent or more of the shares or other ownership of the health care  
170.23 entity to another entity;

170.24 (5) an addition or substitution of one or more members of the health care entity's  
170.25 governing body that effectively transfers control, responsibility for, or governance of the  
170.26 health care entity to another entity;

170.27 (6) the creation of a new health care entity; or

170.28 (7) substantial investment of 30 percent or more in a health care entity that results in  
170.29 sharing of revenues without a change in ownership or voting shares.

170.30 Subd. 2. **Notice required.** (a) This subdivision applies to all transactions where:

171.1 (1) the health care entity involved in the transaction has average revenue of at least  
171.2 \$10,000,000 per year; or

171.3 (2) an entity created by the transaction is projected to have average revenue of at least  
171.4 \$10,000,000 per year once the entity is operating at full capacity.

171.5 (b) A health care entity must provide notice to the attorney general and the commissioner  
171.6 and comply with this subdivision before entering into a transaction. Notice must be provided  
171.7 at least 180 days before the proposed completion date for the transaction.

171.8 (c) As part of the notice required under this subdivision, at least 180 days before the  
171.9 proposed completion date of the transaction, a health care entity must affirmatively disclose  
171.10 the following to the attorney general and the commissioner:

171.11 (1) the entities involved in the transaction;

171.12 (2) the leadership of the entities involved in the transaction, including all directors, board  
171.13 members, and officers;

171.14 (3) the services provided by each entity and the attributed revenue for each entity by  
171.15 location;

171.16 (4) the primary service area for each location;

171.17 (5) the proposed service area for each location;

171.18 (6) the current relationships between the entities and the health care providers and  
171.19 practices affected, the locations of affected health care providers and practices, the services  
171.20 provided by affected health care providers and practices, and the proposed relationships  
171.21 between the entities and the health care providers and practices affected;

171.22 (7) the terms of the transaction agreement or agreements;

171.23 (8) the acquisition price;

171.24 (9) markets in which the entities expect postmerger synergies to produce a competitive  
171.25 advantage;

171.26 (10) potential areas of expansion, whether in existing markets or new markets;

171.27 (11) plans to close facilities, reduce workforce, or reduce or eliminate services;

171.28 (12) the experts and consultants used to evaluate the transaction;

171.29 (13) the number of full-time equivalent positions at each location before and after the  
171.30 transaction by job category, including administrative and contract positions; and

172.1 (14) any other information requested by the attorney general or commissioner.

172.2 (d) As part of the notice required under this subdivision, at least 180 days before the  
172.3 proposed completion date of the transaction, a health care entity must affirmatively produce  
172.4 the following to the attorney general and the commissioner:

172.5 (1) the current governing documents for all entities involved in the transaction and any  
172.6 amendments to these documents;

172.7 (2) the transaction agreement or agreements and all related agreements;

172.8 (3) any collateral agreements related to the principal transaction, including leases,  
172.9 management contracts, and service contracts;

172.10 (4) all expert or consultant reports or valuations conducted in evaluating the transaction,  
172.11 including any valuation of the assets that are subject to the transaction prepared within three  
172.12 years preceding the anticipated transaction completion date and any reports of financial or  
172.13 economic analysis conducted in anticipation of the transaction;

172.14 (5) the results of any projections or modeling of health care utilization or financial  
172.15 impacts related to the transaction, including but not limited to copies of reports by appraisers,  
172.16 accountants, investment bankers, actuaries, and other experts;

172.17 (6) a financial and economic analysis and report prepared by an independent expert or  
172.18 consultant on the effects of the transaction;

172.19 (7) an impact analysis report prepared by an independent expert or consultant on the  
172.20 effects of the transaction on communities and the workforce, including any changes in  
172.21 availability or accessibility of services;

172.22 (8) all documents reflecting the purposes of or restrictions on any related nonprofit  
172.23 entity's charitable assets;

172.24 (9) copies of all filings submitted to federal regulators, including any Hart-Scott-Rodino  
172.25 filing the entities submitted to the Federal Trade Commission in connection with the  
172.26 transaction;

172.27 (10) a certification sworn under oath by each board member and chief executive officer  
172.28 for any nonprofit entity involved in the transaction containing the following: an explanation  
172.29 of how the completed transaction is in the public interest, addressing the factors in subdivision  
172.30 5, paragraph (a); a disclosure of each declarant's compensation and benefits relating to the  
172.31 transaction for the three years following the transaction's anticipated completion date; and  
172.32 a disclosure of any conflicts of interest;

173.1 (11) audited and unaudited financial statements from all entities involved in the  
173.2 transaction and tax filings for all entities involved in the transaction covering the preceding  
173.3 five fiscal years; and

173.4 (12) any other information or documents requested by the attorney general or  
173.5 commissioner.

173.6 (e) The commissioner may adopt rules to implement this section, and may alter, amend,  
173.7 suspend, or repeal any of such rules. The requirements of section 14.125 do not apply to  
173.8 the adoption of rules under this paragraph.

173.9 (f) The attorney general may extend the notice and waiting period required under  
173.10 paragraph (b) for an additional 90 days by notifying the health care entity in writing of the  
173.11 extension.

173.12 (g) The attorney general may waive all or any part of the notice and waiting period  
173.13 required under paragraph (b).

173.14 (h) The attorney general or the commissioner may hold public listening sessions or  
173.15 forums to obtain input on the transaction from providers or community members who may  
173.16 be impacted by the transaction.

173.17 (i) The attorney general or the commissioner may bring an action in district court to  
173.18 compel compliance with the notice requirements in this subdivision.

173.19 Subd. 3. **Prohibited transactions.** No health care entity may enter into a transaction  
173.20 that will:

173.21 (1) substantially lessen competition; or

173.22 (2) tend to create a monopoly or monopsony.

173.23 Subd. 4. **Additional requirements for nonprofit health care entities.** A health care  
173.24 entity that is incorporated under chapter 317A or organized under section 322C.1101, or  
173.25 that is a subsidiary of any such entity, must, before entering into a transaction, ensure that:

173.26 (1) the transaction complies with chapters 317A and 501B and other applicable laws;

173.27 (2) the transaction does not involve or constitute a breach of charitable trust;

173.28 (3) the nonprofit health care entity will receive full and fair value for its public benefit  
173.29 assets;

173.30 (4) the value of the public benefit assets to be transferred has not been manipulated in  
173.31 a manner that causes or has caused the value of the assets to decrease;

174.1 (5) the proceeds of the transaction will be used in a manner consistent with the public  
174.2 benefit for which the assets are held by the nonprofit health care entity;

174.3 (6) the transaction will not result in a breach of fiduciary duty; and

174.4 (7) there are procedures and policies in place to prohibit any officer, director, trustee,  
174.5 or other executive of the nonprofit health care entity from directly or indirectly benefiting  
174.6 from the transaction.

174.7 Subd. 5. Attorney general enforcement and supplemental authority. (a) The attorney  
174.8 general may bring an action in district court to enjoin or unwind a transaction or seek other  
174.9 equitable relief necessary to protect the public interest if a health care entity or transaction  
174.10 violates this section, if the transaction is contrary to the public interest, or if both a health  
174.11 care entity or transaction violates this section and the transaction is contrary to the public  
174.12 interest. Factors informing whether a transaction is contrary to the public interest include  
174.13 but are not limited to whether the transaction:

174.14 (1) will harm public health;

174.15 (2) will reduce the affected community's continued access to affordable and quality care  
174.16 and to the range of services historically provided by the entities or will prevent members  
174.17 in the affected community from receiving a comparable or better patient experience;

174.18 (3) will have a detrimental impact on competing health care options within primary and  
174.19 dispersed service areas;

174.20 (4) will reduce delivery of health care to disadvantaged, uninsured, underinsured, and  
174.21 underserved populations and to populations enrolled in public health care programs;

174.22 (5) will have a substantial negative impact on medical education and teaching programs,  
174.23 health care workforce training, or medical research;

174.24 (6) will have a negative impact on the market for health care services, health insurance  
174.25 services, or skilled health care workers;

174.26 (7) will increase health care costs for patients; or

174.27 (8) will adversely impact provider cost trends and containment of total health care  
174.28 spending.

174.29 (b) The attorney general may enforce this section under section 8.31.

174.30 (c) Failure of the entities involved in a transaction to provide timely information as  
174.31 required by the attorney general or the commissioner shall be an independent and sufficient  
174.32 ground for a court to enjoin the transaction or provide other equitable relief, provided the

175.1 attorney general notified the entities of the inadequacy of the information provided and  
175.2 provided the entities with a reasonable opportunity to remedy the inadequacy.

175.3 (d) The attorney general shall consult with the commissioner to determine whether a  
175.4 transaction is contrary to the public interest. Any information exchanged between the attorney  
175.5 general and the commissioner according to this subdivision is confidential data on individuals  
175.6 as defined in section 13.02, subdivision 3, or protected nonpublic data as defined in section  
175.7 13.02, subdivision 13. The commissioner may share with the attorney general, according  
175.8 to section 13.05, subdivision 9, any not public data, as defined in section 13.02, subdivision  
175.9 8a, held by the Department of Health to aid in the investigation and review of the transaction,  
175.10 and the attorney general must maintain this data with the same classification according to  
175.11 section 13.03, subdivision 4, paragraph (d).

175.12 Subd. 6. **Supplemental authority of commissioner.** (a) Notwithstanding any law to  
175.13 the contrary, the commissioner may use data or information submitted under this section,  
175.14 section 62U.04, and sections 144.695 to 144.705 to conduct analyses of the aggregate impact  
175.15 of health care transactions on access to or the cost of health care services, health care market  
175.16 consolidation, and health care quality.

175.17 (b) The commissioner shall issue periodic public reports on the number and types of  
175.18 transactions subject to this section and on the aggregate impact of transactions on health  
175.19 care cost, quality, and competition in Minnesota.

175.20 Subd. 7. **Relation to other law.** (a) The powers and authority under this section are in  
175.21 addition to, and do not affect or limit, all other rights, powers, and authority of the attorney  
175.22 general or the commissioner under chapter 8, 309, 317A, 325D, 501B, or other law.

175.23 (b) Nothing in this section shall suspend any obligation imposed under chapter 8, 309,  
175.24 317A, 325D, 501B, or other law on the entities involved in a transaction.

175.25 **EFFECTIVE DATE.** This section is effective the day following final enactment and  
175.26 applies to transactions completed on or after that date. In determining whether a transaction  
175.27 was completed on or after the effective date, any actions or series of actions necessary to  
175.28 the completion of the transaction that occurred prior to the effective date must be considered.

175.29 Sec. 79. Minnesota Statutes 2022, section 144.608, subdivision 1, is amended to read:

175.30 Subdivision 1. **Trauma Advisory Council established.** (a) A Trauma Advisory Council  
175.31 is established to advise, consult with, and make recommendations to the commissioner on  
175.32 the development, maintenance, and improvement of a statewide trauma system.

175.33 (b) The council shall consist of the following members:

- 176.1 (1) a trauma surgeon certified by the American Board of Surgery or the American  
176.2 Osteopathic Board of Surgery who practices in a level I or II trauma hospital;
- 176.3 (2) a general surgeon certified by the American Board of Surgery or the American  
176.4 Osteopathic Board of Surgery whose practice includes trauma and who practices in a  
176.5 designated rural area as defined under section 144.1501, subdivision 1, ~~paragraph (e)~~;
- 176.6 (3) a neurosurgeon certified by the American Board of Neurological Surgery who  
176.7 practices in a level I or II trauma hospital;
- 176.8 (4) a trauma program nurse manager or coordinator practicing in a level I or II trauma  
176.9 hospital;
- 176.10 (5) an emergency physician certified by the American Board of Emergency Medicine  
176.11 or the American Osteopathic Board of Emergency Medicine whose practice includes  
176.12 emergency room care in a level I, II, III, or IV trauma hospital;
- 176.13 (6) a trauma program manager or coordinator who practices in a level III or IV trauma  
176.14 hospital;
- 176.15 (7) a physician certified by the American Board of Family Medicine or the American  
176.16 Osteopathic Board of Family Practice whose practice includes emergency department care  
176.17 in a level III or IV trauma hospital located in a designated rural area as defined under section  
176.18 144.1501, subdivision 1, ~~paragraph (e)~~;
- 176.19 (8) a nurse practitioner, as defined under section 144.1501, subdivision 1, ~~paragraph (f)~~,  
176.20 or a physician assistant, as defined under section 144.1501, subdivision 1, ~~paragraph (g)~~,  
176.21 whose practice includes emergency room care in a level IV trauma hospital located in a  
176.22 designated rural area as defined under section 144.1501, subdivision 1, ~~paragraph (e)~~;
- 176.23 (9) a physician certified in pediatric emergency medicine by the American Board of  
176.24 Pediatrics or certified in pediatric emergency medicine by the American Board of Emergency  
176.25 Medicine or certified by the American Osteopathic Board of Pediatrics whose practice  
176.26 primarily includes emergency department medical care in a level I, II, III, or IV trauma  
176.27 hospital, or a surgeon certified in pediatric surgery by the American Board of Surgery whose  
176.28 practice involves the care of pediatric trauma patients in a trauma hospital;
- 176.29 (10) an orthopedic surgeon certified by the American Board of Orthopaedic Surgery or  
176.30 the American Osteopathic Board of Orthopedic Surgery whose practice includes trauma  
176.31 and who practices in a level I, II, or III trauma hospital;
- 176.32 (11) the state emergency medical services medical director appointed by the Emergency  
176.33 Medical Services Regulatory Board;

177.1 (12) a hospital administrator of a level III or IV trauma hospital located in a designated  
177.2 rural area as defined under section 144.1501, subdivision 1, ~~paragraph (e)~~;

177.3 (13) a rehabilitation specialist whose practice includes rehabilitation of patients with  
177.4 major trauma injuries or traumatic brain injuries and spinal cord injuries as defined under  
177.5 section 144.661;

177.6 (14) an attendant or ambulance director who is an EMT, EMT-I, or EMT-P within the  
177.7 meaning of section 144E.001 and who actively practices with a licensed ambulance service  
177.8 in a primary service area located in a designated rural area as defined under section 144.1501,  
177.9 subdivision 1, ~~paragraph (e)~~; and

177.10 (15) the commissioner of public safety or the commissioner's designee.

177.11 Sec. 80. Minnesota Statutes 2022, section 144.615, subdivision 7, is amended to read:

177.12 Subd. 7. **Limitations of services.** (a) The following limitations apply to the services  
177.13 performed at a birth center:

177.14 (1) surgical procedures must be limited to those normally accomplished during an  
177.15 uncomplicated birth, including episiotomy and repair; and

177.16 ~~(2) no abortions may be administered; and~~

177.17 ~~(3)~~ (2) no general or regional anesthesia may be administered.

177.18 (b) Notwithstanding paragraph (a), local anesthesia may be administered at a birth center  
177.19 if the administration of the anesthetic is performed within the scope of practice of a health  
177.20 care professional.

177.21 **EFFECTIVE DATE.** This section is effective the day following final enactment.

177.22 Sec. 81. Minnesota Statutes 2022, section 144.651, is amended by adding a subdivision  
177.23 to read:

177.24 Subd. 10a. **Designated support person for pregnant patient.** (a) A health care provider  
177.25 and a health care facility must allow, at a minimum, one designated support person of a  
177.26 pregnant patient's choosing to be physically present while the patient is receiving health  
177.27 care services including during a hospital stay.

177.28 (b) For purposes of this subdivision, "designated support person" means any person  
177.29 necessary to provide comfort to the patient including but not limited to the patient's spouse,  
177.30 partner, family member, or another person related by affinity. Certified doulas and traditional  
177.31 midwives may not be counted toward the limit of one designated support person.

178.1 Sec. 82. Minnesota Statutes 2022, section 144.653, subdivision 5, is amended to read:

178.2 Subd. 5. **Correction orders.** Whenever a duly authorized representative of the state  
178.3 commissioner of health finds upon inspection of a facility required to be licensed under the  
178.4 provisions of sections 144.50 to 144.58 that the licensee of such facility is not in compliance  
178.5 with sections 144.411 to 144.417, 144.50 to 144.58, 144.651, 144.7051 to 144.7058, or  
178.6 626.557, or the applicable rules promulgated under those sections, a correction order shall  
178.7 be issued to the licensee. The correction order shall state the deficiency, cite the specific  
178.8 rule violated, and specify the time allowed for correction.

178.9 Sec. 83. Minnesota Statutes 2022, section 144.6535, subdivision 1, is amended to read:

178.10 Subdivision 1. **Request for variance or waiver.** A hospital may request that the  
178.11 commissioner grant a variance or waiver from the provisions of ~~Minnesota Rules, chapter~~  
178.12 ~~4640 or 4645~~ section 144.55, subdivision 3, paragraph (b). A request for a variance or waiver  
178.13 must be submitted to the commissioner in writing. Each request must contain:

- 178.14 (1) the specific ~~rule or rules~~ requirement for which the variance or waiver is requested;
- 178.15 (2) the reasons for the request;
- 178.16 (3) the alternative measures that will be taken if a variance or waiver is granted;
- 178.17 (4) the length of time for which the variance or waiver is requested; and
- 178.18 (5) other relevant information deemed necessary by the commissioner to properly evaluate  
178.19 the request for the variance or waiver.

178.20 **EFFECTIVE DATE.** This section is effective January 1, 2024.

178.21 Sec. 84. Minnesota Statutes 2022, section 144.6535, subdivision 2, is amended to read:

178.22 Subd. 2. **Criteria for evaluation.** The decision to grant or deny a variance or waiver  
178.23 must be based on the commissioner's evaluation of the following criteria:

- 178.24 (1) whether the variance or waiver will adversely affect the health, treatment, comfort,  
178.25 safety, or well-being of a patient;
- 178.26 (2) whether the alternative measures to be taken, if any, are equivalent to or superior to  
178.27 those prescribed in ~~Minnesota Rules, chapter 4640 or 4645~~ section 144.55, subdivision 3,  
178.28 paragraph (b); and
- 178.29 (3) whether compliance with the ~~rule or rules~~ requirements would impose an undue  
178.30 burden upon the applicant.

179.1 **EFFECTIVE DATE.** This section is effective January 1, 2024.

179.2 Sec. 85. Minnesota Statutes 2022, section 144.6535, subdivision 4, is amended to read:

179.3 Subd. 4. **Effect of alternative measures or conditions.** (a) Alternative measures or  
179.4 conditions attached to a variance or waiver have the same force and effect as the ~~rules~~  
179.5 requirement under Minnesota Rules, chapter ~~4640 or 4645~~ section 144.55, subdivision 3,  
179.6 paragraph (b), and are subject to the issuance of correction orders and penalty assessments  
179.7 in accordance with section 144.55.

179.8 (b) Fines for a violation of this section shall be in the same amount as that specified for  
179.9 the particular ~~rule~~ requirement for which the variance or waiver was requested.

179.10 **EFFECTIVE DATE.** This section is effective January 1, 2024.

179.11 Sec. 86. Minnesota Statutes 2022, section 144.69, is amended to read:

179.12 **144.69 CLASSIFICATION OF DATA ON INDIVIDUALS.**

179.13 Subdivision 1. Data collected by the cancer reporting system. Notwithstanding any  
179.14 law to the contrary, including section 13.05, subdivision 9, data collected on individuals by  
179.15 the cancer ~~surveillance~~ reporting system, including the names and personal identifiers of  
179.16 persons required in section 144.68 to report, shall be private and may only be used for the  
179.17 purposes set forth in this section and sections 144.671, 144.672, and 144.68. Any disclosure  
179.18 other than is provided for in this section and sections 144.671, 144.672, and 144.68, is  
179.19 declared to be a misdemeanor and punishable as such. Except as provided by rule, and as  
179.20 part of an epidemiologic investigation, an officer or employee of the commissioner of health  
179.21 may interview patients named in any such report, or relatives of any such patient, only after  
179.22 ~~the consent of~~ notifying the attending physician, advanced practice registered nurse, physician  
179.23 assistant, or surgeon ~~is obtained.~~ Research protections for patients must be consistent with  
179.24 section 13.04, subdivision 2, and Code of Federal Regulations, title 45, part 46.

179.25 Subd. 2. **Transfers of information to state cancer registries and federal government**  
179.26 **agencies.** (a) Information containing personal identifiers of a non-Minnesota resident  
179.27 collected by the cancer reporting system may be provided to the statewide cancer registry  
179.28 of the nonresident's home state solely for the purposes consistent with this section and  
179.29 sections 144.671, 144.672, and 144.68, provided that the other state agrees to maintain the  
179.30 classification of the information as provided under subdivision 1.

179.31 (b) Information, excluding direct identifiers such as name, Social Security number,  
179.32 telephone number, and street address, collected by the cancer reporting system may be

180.1 provided to the Centers for Disease Control and Prevention's National Program of Cancer  
180.2 Registries and the National Cancer Institute's Surveillance, Epidemiology, and End Results  
180.3 Program registry.

180.4 Sec. 87. [144.7051] DEFINITIONS.

180.5 Subdivision 1. **Applicability.** For the purposes of sections 144.7051 to 144.7058, the  
180.6 terms defined in this section have the meanings given.

180.7 Subd. 2. **Concern for safe staffing form.** "Concern for safe staffing form" means a  
180.8 standard uniform form developed by the commissioner that may be used by any individual  
180.9 to report unsafe staffing situations while maintaining the privacy of patients.

180.10 Subd. 3. **Commissioner.** "Commissioner" means the commissioner of health.

180.11 Subd. 4. **Daily staffing schedule.** "Daily staffing schedule" means the actual number  
180.12 of full-time equivalent nonmanagerial care staff assigned to an inpatient care unit and  
180.13 providing care in that unit during a 24-hour period and the actual number of patients assigned  
180.14 to each direct care registered nurse present and providing care in the unit.

180.15 Subd. 5. **Direct-care registered nurse.** "Direct-care registered nurse" means a registered  
180.16 nurse, as defined in section 148.171, subdivision 20, who is nonsupervisory and  
180.17 nonmanagerial and who directly provides nursing care to patients more than 60 percent of  
180.18 the time.

180.19 Subd. 6. **Hospital.** "Hospital" means any setting that is licensed under this chapter as a  
180.20 hospital.

180.21 **EFFECTIVE DATE.** This section is effective July 1, 2025.

180.22 Sec. 88. [144.7053] HOSPITAL NURSE STAFFING COMMITTEE.

180.23 Subdivision 1. **Hospital nurse staffing committee required.** (a) Each hospital must  
180.24 establish and maintain a functioning hospital nurse staffing committee. A hospital may  
180.25 assign the functions and duties of a hospital nurse staffing committee to an existing committee  
180.26 provided the existing committee meets the membership requirements applicable to a hospital  
180.27 nurse staffing committee.

180.28 (b) The commissioner is not required to verify compliance with this section by an on-site  
180.29 visit.

180.30 Subd. 2. **Staffing committee membership.** (a) At least 35 percent of the hospital nurse  
180.31 staffing committee's membership must be direct care registered nurses typically assigned

181.1 to a specific unit for an entire shift and at least 15 percent of the committee's membership  
181.2 must be other direct care workers typically assigned to a specific unit for an entire shift.  
181.3 Direct care registered nurses and other direct care workers who are members of a collective  
181.4 bargaining unit shall be appointed or elected to the committee according to the guidelines  
181.5 of the applicable collective bargaining agreement. If there is no collective bargaining  
181.6 agreement, direct care registered nurses shall be elected to the committee by direct care  
181.7 registered nurses employed by the hospital and other direct care workers shall be elected  
181.8 to the committee by other direct care workers employed by the hospital.

181.9 (b) The hospital shall appoint 50 percent of the hospital nurse staffing committee's  
181.10 membership.

181.11 Subd. 3. **Staffing committee compensation.** A hospital must treat participation in the  
181.12 hospital nurse staffing committee meetings by any hospital employee as scheduled work  
181.13 time and compensate each committee member at the employee's existing rate of pay. A  
181.14 hospital must relieve all direct care registered nurse members of the hospital nurse staffing  
181.15 committee of other work duties during the times when the committee meets.

181.16 Subd. 4. **Staffing committee meeting frequency.** Each hospital nurse staffing committee  
181.17 must meet at least quarterly.

181.18 Subd. 5. **Staffing committee duties.** (a) Each hospital nurse staffing committee shall  
181.19 create, implement, continuously evaluate, and update as needed evidence-based written  
181.20 core staffing plans to guide the creation of daily staffing schedules for each inpatient care  
181.21 unit of the hospital.

181.22 (b) Each hospital nurse staffing committee must:

181.23 (1) establish a secure, uniform, and easily accessible method for any hospital employee,  
181.24 patient, or patient family member to submit directly to the committee a concern for safe  
181.25 staffing form;

181.26 (2) review each concern for safe staffing form;

181.27 (3) forward a copy of all concern for safe staffing forms to the relevant hospital nurse  
181.28 workload committee;

181.29 (4) review the documentation of compliance maintained by the hospital under section  
181.30 144.7056, subdivision 10;

181.31 (5) conduct a trend analysis of the data related to all reported concerns regarding safe  
181.32 staffing;

- 182.1 (6) develop a mechanism for tracking and analyzing staffing trends within the hospital;
- 182.2 (7) submit a nurse staffing report to the commissioner;
- 182.3 (8) assist the commissioner in compiling data for the Nursing Workforce Report by
- 182.4 encouraging participation in the commissioner's independent study on reasons licensed
- 182.5 registered nurses are leaving the profession; and
- 182.6 (9) record in the committee minutes for each meeting a summary of the discussions and
- 182.7 recommendations of the committee. Each committee must maintain the minutes, records,
- 182.8 and distributed materials for five years.

182.9 **EFFECTIVE DATE.** This section is effective July 1, 2025.

182.10 Sec. 89. **[144.7054] HOSPITAL NURSE WORKLOAD COMMITTEE.**

182.11 Subdivision 1. **Hospital nurse workload committee required.** (a) Each hospital must

182.12 establish and maintain functioning hospital nurse workload committees for each unit.

182.13 (b) The commissioner is not required to verify compliance with this section by an on-site

182.14 visit.

182.15 Subd. 2. **Workload committee membership.** (a) At least 35 percent of each workload

182.16 committee's membership must be direct care registered nurses typically assigned to the unit

182.17 for an entire shift and at least 15 percent of the committee's membership must be other direct

182.18 care workers typically assigned to the unit for an entire shift. Direct care registered nurses

182.19 and other direct care workers who are members of a collective bargaining unit shall be

182.20 appointed or elected to the committee according to the guidelines of the applicable collective

182.21 bargaining agreement. If there is no collective bargaining agreement, direct care registered

182.22 nurses shall be elected to the committee by direct care registered nurses typically assigned

182.23 to the unit for an entire shift and other direct care workers shall be elected to the committee

182.24 by other direct care workers typically assigned to the unit for an entire shift.

182.25 (b) The hospital shall appoint 50 percent of each unit's nurse workload committee's

182.26 membership.

182.27 (c) Notwithstanding paragraphs (a) and (b), if a hospital has established a staffing

182.28 committee through collective bargaining, then the composition of that committee prevails.

182.29 Subd. 3. **Workload committee compensation.** A hospital must treat participation in a

182.30 hospital nurse workload committee meeting by any hospital employee as scheduled work

182.31 time and compensate each committee member at the employee's existing rate of pay. A

183.1 hospital must relieve all direct care registered nurse members of a hospital nurse workload  
183.2 committee of other work duties during the times when the committee meets.

183.3 Subd. 4. **Workload committee meeting frequency.** Each hospital nurse workload  
183.4 committee must meet at least monthly whenever the committee is in receipt of an unresolved  
183.5 concern for safe staffing form.

183.6 Subd. 5. **Workload committee duties.** (a) Each hospital nurse workload committee  
183.7 must create, implement, and maintain dispute resolution procedures to guide the committee's  
183.8 development and implementation of solutions to the staffing concerns raised in concern for  
183.9 safe staffing forms that have been forwarded to the committee. The dispute resolution  
183.10 procedures must include an expedited arbitration process with an arbitrator who has expertise  
183.11 in patient care. The committee must use the expedited arbitration process for any complaint  
183.12 that remains unresolved 30 days after the submission of the concern for safe staffing form  
183.13 that gave rise to the complaint.

183.14 (b) Each hospital nurse workload committee must attempt to expeditiously resolve  
183.15 staffing issues the committee determines arise from a violation of the hospital's core staffing  
183.16 plan.

183.17 **EFFECTIVE DATE.** This section is effective July 1, 2025.

183.18 Sec. 90. Minnesota Statutes 2022, section 144.7055, is amended to read:

183.19 **144.7055 HOSPITAL CORE STAFFING PLAN REPORTS.**

183.20 Subdivision 1. **Definitions.** (a) For the purposes of ~~this section~~ sections 144.7051 to  
183.21 144.7058, the following terms have the meanings given.

183.22 (b) "Core staffing plan" means ~~the projected number of full-time equivalent~~  
183.23 ~~nonmanagerial care staff that will be assigned in a 24-hour period to an inpatient care unit~~  
183.24 a plan described in subdivision 2.

183.25 (c) "Nonmanagerial care staff" means registered nurses, licensed practical nurses, and  
183.26 other health care workers, which may include but is not limited to nursing assistants, nursing  
183.27 aides, patient care technicians, and patient care assistants, who perform nonmanagerial  
183.28 direct patient care functions for more than 50 percent of their scheduled hours on a given  
183.29 patient care unit.

183.30 (d) "Inpatient care unit" or "unit" means a designated inpatient area for assigning patients  
183.31 and staff for which a ~~distinct staffing plan~~ daily staffing schedule exists and that operates

184.1 24 hours per day, seven days per week in a hospital setting. Inpatient care unit does not  
184.2 include any hospital-based clinic, long-term care facility, or outpatient hospital department.

184.3 (e) "Staffing hours per patient day" means the number of full-time equivalent  
184.4 nonmanagerial care staff who will ordinarily be assigned to provide direct patient care  
184.5 divided by the expected average number of patients upon which such assignments are based.

184.6 ~~(f) "Patient acuity tool" means a system for measuring an individual patient's need for~~  
184.7 ~~nursing care. This includes utilizing a professional registered nursing assessment of patient~~  
184.8 ~~condition to assess staffing need.~~

184.9 Subd. 2. **Hospital core staffing report plans.** (a) ~~The chief nursing executive or nursing~~  
184.10 ~~designee hospital nurse staffing committee~~ of every ~~reporting~~ hospital in Minnesota under  
184.11 ~~section 144.50 will~~ must develop a core staffing plan for each ~~patient~~ inpatient care unit.

184.12 (b) The commissioner is not required to verify compliance with this section by an on-site  
184.13 visit.

184.14 ~~(b)~~ (c) Core staffing plans shall must specify all of the following:

184.15 (1) the projected number of full-time equivalent for nonmanagerial care staff that will  
184.16 be assigned in a 24-hour period to each patient inpatient care unit for each 24-hour period;

184.17 (2) the maximum number of patients on each inpatient care unit for whom a direct care  
184.18 nurse can typically safely care;

184.19 (3) criteria for determining when circumstances exist on each inpatient care unit such  
184.20 that a direct care nurse cannot safely care for the typical number of patients and when  
184.21 assigning a lower number of patients to each nurse on the inpatient unit would be appropriate;

184.22 (4) a procedure for each inpatient care unit to make shift-to-shift adjustments in staffing  
184.23 levels when such adjustments are required by patient acuity and nursing intensity in the  
184.24 unit;

184.25 (5) a contingency plan for each inpatient unit to safely address circumstances in which  
184.26 patient care needs unexpectedly exceed the staffing resources provided for in a daily staffing  
184.27 schedule. A contingency plan must include a method to quickly identify, for each daily  
184.28 staffing schedule, additional direct care registered nurses who are available to provide direct  
184.29 care on the inpatient care unit;

184.30 (6) strategies to enable direct care registered nurses to take breaks they are entitled to  
184.31 under law or under an applicable collective bargaining agreement; and

185.1 (7) strategies to eliminate patient boarding in emergency departments that do not rely  
185.2 on requiring direct care registered nurses to work additional hours to provide care.

185.3 (e) (d) Core staffing plans must ensure that:

185.4 (1) the person creating a daily staffing schedule has sufficiently detailed information to  
185.5 create a daily staffing schedule that meets the requirements of the plan;

185.6 (2) daily staffing schedules do not rely on assigning individual nonmanagerial care staff  
185.7 to work overtime hours in excess of 16 hours in a 24-hour period or to work consecutive  
185.8 24-hour periods requiring 16 or more hours;

185.9 (3) a direct care registered nurse is not required or expected to perform functions outside  
185.10 the nurse's professional license;

185.11 (4) a light duty direct care registered nurse is given appropriate assignments;

185.12 (5) a charge nurse does not have patient assignments; and

185.13 (6) daily staffing schedules do not interfere with applicable collective bargaining  
185.14 agreements.

185.15 Subd. 2a. **Development of hospital core staffing plans.** (a) Prior to submitting  
185.16 completing or updating the core staffing plan, as required in subdivision 3, hospitals shall  
185.17 a hospital nurse staffing committee must consult with representatives of the hospital medical  
185.18 staff, managerial and nonmanagerial care staff, and other relevant hospital personnel about  
185.19 the core staffing plan and the expected average number of patients upon which the core  
185.20 staffing plan is based.

185.21 (b) When developing a core staffing plan, a hospital nurse staffing committee must  
185.22 consider all of the following:

185.23 (1) the individual needs and expected census of each inpatient care unit;

185.24 (2) unit-specific patient acuity, including fall risk and behaviors requiring intervention,  
185.25 such as physical aggression toward self or others or destruction of property;

185.26 (3) unit-specific demands on direct care registered nurses' time, including: frequency of  
185.27 admissions, discharges, and transfers; frequency and complexity of patient evaluations and  
185.28 assessments; frequency and complexity of nursing care planning; planning for patient  
185.29 discharge; assessing for patient referral; patient education; and implementing infectious  
185.30 disease protocols;

185.31 (4) the architecture and geography of the inpatient care unit, including the placement of  
185.32 patient rooms, treatment areas, nursing stations, medication preparation areas, and equipment;

186.1 (5) mechanisms and procedures to provide for one-to-one patient observation for patients  
186.2 on psychiatric or other units;

186.3 (6) the stress that direct-care nurses experience when required to work extreme amounts  
186.4 of overtime, such as shifts in excess of 12 hours or multiple consecutive double shifts;

186.5 (7) the need for specialized equipment and technology on the unit;

186.6 (8) other special characteristics of the unit or community patient population, including  
186.7 age, cultural and linguistic diversity and needs, functional ability, communication skills,  
186.8 and other relevant social and socioeconomic factors;

186.9 (9) the skill mix of personnel other than direct care registered nurses providing or  
186.10 supporting direct patient care on the unit;

186.11 (10) mechanisms and procedures for identifying additional registered nurses who are  
186.12 available for direct patient care when patients' unexpected needs exceed the planned workload  
186.13 for direct care staff; and

186.14 (11) demands on direct care registered nurses' time not directly related to providing  
186.15 direct care on a unit, such as involvement in quality improvement activities, professional  
186.16 development, service to the hospital, including serving on the hospital nurse staffing  
186.17 committee or the hospital nurse workload committee, and service to the profession.

186.18 Subd. 2b. **Failure to develop hospital core staffing plans.** If a hospital nurse staffing  
186.19 committee cannot approve a hospital core staffing plan by a majority vote, the members of  
186.20 the nurse staffing committee must enter an expedited arbitration process with an arbitrator  
186.21 who understands patient care needs.

186.22 Subd. 2c. **Objections to hospital core staffing plans.** (a) If hospital management objects  
186.23 to a core staffing plan approved by a majority vote of the hospital nurse staffing committee,  
186.24 the hospital may elect to attempt to amend the core staffing plan through arbitration.

186.25 (b) During an ongoing dispute resolution process, a hospital must continue to implement  
186.26 the core staffing plan as written and approved by the hospital nurse staffing committee.

186.27 (c) If the dispute resolution process results in an amendment to the core staffing plan,  
186.28 the hospital must implement the amended core staffing plan.

186.29 Subd. 2d. **Mandatory submission of core staffing plan to commissioner.** Each hospital  
186.30 must submit to the commissioner the core staffing plans approved by the hospital's nurse  
186.31 staffing committee. A hospital must submit any substantial updates to any previously

187.1 approved plan, including any amendments to the plan resulting from arbitration, within 30  
187.2 calendar days of approval of the update by the committee or the conclusion of arbitration.

187.3 ~~Subd. 3. **Standard electronic reporting developed.** (a) Hospitals must submit the core~~  
187.4 ~~staffing plans to the Minnesota Hospital Association by January 1, 2014. The Minnesota~~  
187.5 ~~Hospital Association shall include each reporting hospital's core staffing plan on the~~  
187.6 ~~Minnesota Hospital Association's Minnesota Hospital Quality Report website by April 1,~~  
187.7 ~~2014. any substantial changes to the core staffing plan shall be updated within 30 days.~~

187.8 ~~(b) The Minnesota Hospital Association shall include on its website for each reporting~~  
187.9 ~~hospital on a quarterly basis the actual direct patient care hours per patient and per unit.~~  
187.10 ~~Hospitals must submit the direct patient care report to the Minnesota Hospital Association~~  
187.11 ~~by July 1, 2014, and quarterly thereafter.~~

187.12 **EFFECTIVE DATE.** This section is effective July 1, 2025.

187.13 Sec. 91. **[144.7056] IMPLEMENTATION OF HOSPITAL CORE STAFFING PLANS.**

187.14 Subdivision 1. **Plan implementation required.** (a) A hospital must implement the core  
187.15 staffing plans approved by a majority vote of its hospital nurse staffing committee.

187.16 (b) The commissioner is not required to verify compliance with this section by on-site  
187.17 visits during routine hospital surveys.

187.18 Subd. 2. **Public posting of core staffing plans.** A hospital must post its core staffing  
187.19 plan for each inpatient care unit in a public area on the relevant unit.

187.20 Subd. 3. **Public posting of compliance with plan.** For each publicly posted core staffing  
187.21 plan, a hospital must post a notice stating whether the current staffing on the unit complies  
187.22 with the hospital's core staffing plan for that unit. The public notice of compliance must  
187.23 include a list of the number of nonmanagerial care staff working on the unit during the  
187.24 current shift and the number of patients assigned to each direct care registered nurse working  
187.25 on the unit during the current shift. The list must enumerate the nonmanagerial care staff  
187.26 by health care worker type. The public notice of compliance must be posted immediately  
187.27 adjacent to the publicly posted core staffing plan.

187.28 Subd. 4. **Posting of compliance in patient rooms.** A hospital must post on a whiteboard  
187.29 in a patient's room or make available through a television in a patient's room both the number  
187.30 of patients a nurse on the patient's unit should be assigned under the relevant core staffing  
187.31 plan and the number of patients actually assigned to a nurse during the current shift.

188.1 Subd. 5. **Deviations from core staffing plans.** (a) Before hospital management lowers  
188.2 the staffing level of any unit, management must consult with and receive agreement from  
188.3 at least 50 percent of the direct care registered nurses staffing the unit.

188.4 (b) Deviation from a core staffing plan with the agreement of at least 50 percent of the  
188.5 direct care registered nurses staffing the unit does not constitute compliance with the core  
188.6 staffing plan.

188.7 Subd. 6. **Public posting of emergency department wait times.** A hospital must maintain  
188.8 on its website and publicly display in its emergency department the approximate wait time  
188.9 for patients who are not in critical need of emergency care. The approximate wait time must  
188.10 be updated at least hourly.

188.11 Subd. 7. **Disclosure of staffing plan upon admission.** A hospital must provide an  
188.12 explanation of its core staffing plan to each patient upon admission.

188.13 Subd. 8. **Public distribution of core staffing plan and notice of compliance.** (a) A  
188.14 hospital must include with the posted materials described in subdivisions 2 and 3 a statement  
188.15 that individual copies of the posted materials are available upon request to any patient on  
188.16 the unit or to any visitor of a patient on the unit. The statement must include specific  
188.17 instructions for obtaining copies of the posted materials.

188.18 (b) A hospital must, within four hours after the request, provide individual copies of all  
188.19 the posted materials described in subdivisions 2 and 3 to any patient on the unit or to any  
188.20 visitor of a patient on the unit who requests the materials.

188.21 Subd. 9. **Reporting noncompliance.** (a) Any hospital employee, patient, or patient  
188.22 family member may submit a concern for safe staffing form to report an instance of  
188.23 noncompliance with a hospital's core staffing plan, to object to the contents of a core staffing  
188.24 plan, or to challenge the process of the hospital nurse staffing committee.

188.25 (b) A hospital must not interfere with or retaliate against a hospital employee for  
188.26 submitting a concern for safe staffing form.

188.27 (c) The commissioner of labor and industry may investigate any report of retaliation  
188.28 against a hospital employee for submitting a concern for safe staffing form. The commissioner  
188.29 of labor and industry may fine a hospital up to \$250,000 for each instance of substantiated  
188.30 retaliation against a hospital employee for submitting a concern for safe staffing form.

188.31 Subd. 10. **Documentation of compliance.** Each hospital must document compliance  
188.32 with its core nursing plans and maintain records demonstrating compliance for each inpatient

189.1 care unit for five years. Each hospital must provide to its nurse staffing committee access  
189.2 to all documentation required under this subdivision.

189.3 **EFFECTIVE DATE.** This section is effective October 1, 2025.

189.4 Sec. 92. **[144.7057] HOSPITAL NURSE STAFFING REPORTS.**

189.5 Subdivision 1. **Nurse staffing report required.** Each hospital nurse staffing committee  
189.6 must submit quarterly nurse staffing reports to the commissioner. Reports must be submitted  
189.7 within 60 days of the end of the quarter.

189.8 Subd. 2. **Nurse staffing report.** Nurse staffing reports submitted to the commissioner  
189.9 by a hospital nurse staffing committee must:

189.10 (1) identify any suspected incidents of the hospital failing during the reporting quarter  
189.11 to meet the standards of one of its core staffing plans;

189.12 (2) identify each occurrence of the hospital accepting an elective surgery at a time when  
189.13 the unit performing the surgery is out of compliance with its core staffing plan;

189.14 (3) identify problems of insufficient staffing, including but not limited to:

189.15 (i) inappropriate number of direct care registered nurses scheduled in a unit;

189.16 (ii) inappropriate number of direct care registered nurses present and delivering care in  
189.17 a unit;

189.18 (iii) inappropriately experienced direct care registered nurses scheduled for a particular  
189.19 unit;

189.20 (iv) inappropriately experienced direct care registered nurses present and delivering care  
189.21 in a unit;

189.22 (v) inability for nurse supervisors to adjust daily nursing schedules for increased patient  
189.23 acuity or nursing intensity in a unit; and

189.24 (vi) chronically unfilled direct care positions within the hospital;

189.25 (4) identify any units that pose a risk to patient safety due to inadequate staffing;

189.26 (5) propose solutions to solve insufficient staffing;

189.27 (6) propose solutions to reduce risks to patient safety in inadequately staffed units; and

189.28 (7) describe staffing trends within the hospital.

190.1 Subd. 3. **Public posting of nurse staffing reports.** The commissioner must include on  
190.2 its website each quarterly nurse staffing report submitted to the commissioner under  
190.3 subdivision 1.

190.4 Subd. 4. **Standardized reporting.** The commissioner shall develop and provide to each  
190.5 hospital nurse staffing committee a uniform format or standard form the committee must  
190.6 use to comply with the nurse staffing reporting requirements under this section. The format  
190.7 or form developed by the commissioner must present the reported information in a manner  
190.8 allowing patients and the public to clearly understand and compare staffing patterns and  
190.9 actual levels of staffing across reporting hospitals. The commissioner must include, in the  
190.10 uniform format or on the standardized form, space to allow the reporting hospital to include  
190.11 a description of additional resources available to support unit-level patient care and a  
190.12 description of the hospital.

190.13 Subd. 5. **Penalties.** Notwithstanding section 144.653, subdivisions 5 and 6, the  
190.14 commissioner may impose an immediate fine of up to \$5,000 for each instance of a failure  
190.15 to report an elective surgery requiring reporting under subdivision 2, clause (2). The facility  
190.16 may request a hearing on the immediate fine under section 144.653, subdivision 8.

190.17 **EFFECTIVE DATE.** This section is effective October 1, 2025.

190.18 Sec. 93. **[144.7058] GRADING OF COMPLIANCE WITH CORE STAFFING PLANS.**

190.19 Subdivision 1. **Grading compliance with core staffing plans.** By January 1, 2026, the  
190.20 commissioner must develop a uniform annual grading system that evaluates each hospital's  
190.21 compliance with its own core staffing plan. The commissioner must assign each hospital a  
190.22 compliance grade based on a review of the hospital's nurse staffing report submitted under  
190.23 section 144.7057. The commissioner must assign a failing compliance grade to any hospital  
190.24 that has not been in compliance with its staffing plan for six or more months during the  
190.25 reporting year.

190.26 Subd. 2. **Grading factors.** When grading a hospital's compliance with its core staffing  
190.27 plan, the commissioner must consider at least the following factors:

190.28 (1) the number of assaults and injuries occurring in the hospital involving patients;

190.29 (2) the prevalence of infections, pressure ulcers, and falls among patients;

190.30 (3) emergency department wait times;

190.31 (4) readmissions;

190.32 (5) use of restraints and other behavior interventions;

191.1 (6) employment turnover rates among direct care registered nurses and other direct care  
191.2 health care workers;

191.3 (7) prevalence of overtime among direct care registered nurses and other direct care  
191.4 health care workers;

191.5 (8) prevalence of missed shift breaks among direct care registered nurses and other direct  
191.6 care health care workers;

191.7 (9) frequency of incidents of being out of compliance with a core staffing plan; and

191.8 (10) the extent of noncompliance with a core staffing plan.

191.9 Subd. 3. **Public disclosure of compliance grades.** Beginning January 1, 2027, the  
191.10 commissioner must publish a compliance grade for each hospital on the department website  
191.11 with a link to the hospital's core staffing plan, the hospital's nurse staffing reports, and an  
191.12 accessible and easily understandable explanation of what the compliance grade means.

191.13 **EFFECTIVE DATE.** This section is effective January 1, 2026.

191.14 Sec. 94. **[144.7059] RETALIATION AGAINST NURSES PROHIBITED.**

191.15 Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have  
191.16 the meanings given.

191.17 (b) "Emergency" means a period when replacement staff are not able to report for duty  
191.18 for the next shift, or a period of increased patient need, because of unusual, unpredictable,  
191.19 or unforeseen circumstances, including but not limited to an act of terrorism, a disease  
191.20 outbreak, adverse weather conditions, or a natural disaster, that impacts continuity of patient  
191.21 care.

191.22 (c) "Nurse" has the meaning given in section 148.171, subdivision 9, and includes nurses  
191.23 employed by the state.

191.24 (d) "Taking action against" means discharging, disciplining, threatening, reporting to  
191.25 the Board of Nursing, discriminating against, or penalizing regarding compensation, terms,  
191.26 conditions, location, or privileges of employment.

191.27 Subd. 2. **Prohibited actions.** Except as provided in subdivision 5, a hospital or other  
191.28 entity licensed under sections 144.50 to 144.58, and its agent, or other health care facility  
191.29 licensed by the commissioner of health, and the facility's agent, is prohibited from taking  
191.30 action against a nurse solely on the ground that the nurse fails to accept an assignment of  
191.31 one or more additional patients because the nurse determines that accepting an additional  
191.32 patient assignment, in the nurse's judgment, may create an unnecessary danger to a patient's

192.1 life, health, or safety or may otherwise constitute a ground for disciplinary action under  
192.2 section 148.261. This subdivision does not apply to a nursing facility, an intermediate care  
192.3 facility for persons with developmental disabilities, or a licensed boarding care home.

192.4 Subd. 3. **State nurses.** Subdivision 2 applies to nurses employed by the state regardless  
192.5 of the type of facility where the nurse is employed and regardless of the facility's license,  
192.6 if the nurse is involved in resident or patient care.

192.7 Subd. 4. **Collective bargaining rights.** This section does not diminish or impair the  
192.8 rights of a person under any collective bargaining agreement.

192.9 Subd. 5. **Emergency.** A nurse may be required to accept an additional patient assignment  
192.10 in an emergency.

192.11 Subd. 6. **Enforcement.** The commissioner of labor and industry shall enforce this section.  
192.12 The commissioner of labor and industry may assess a fine of up to \$5,000 for each violation  
192.13 of this section.

192.14 Sec. 95. Minnesota Statutes 2022, section 144.7067, subdivision 1, is amended to read:

192.15 Subdivision 1. **Establishment of reporting system.** (a) The commissioner shall establish  
192.16 an adverse health event reporting system designed to facilitate quality improvement in the  
192.17 health care system. The reporting system shall not be designed to punish errors by health  
192.18 care practitioners or health care facility employees.

192.19 (b) The reporting system shall consist of:

192.20 (1) mandatory reporting by facilities of 27 adverse health care events;

192.21 (2) mandatory reporting by facilities of whether the unit where an adverse event occurred  
192.22 was in compliance with the core staffing plan for the unit at the time of the adverse event;

192.23 (3) mandatory completion of a root cause analysis and a corrective action plan by the  
192.24 facility and reporting of the findings of the analysis and the plan to the commissioner or  
192.25 reporting of reasons for not taking corrective action;

192.26 ~~(3)~~ (4) analysis of reported information by the commissioner to determine patterns of  
192.27 systemic failure in the health care system and successful methods to correct these failures;

192.28 ~~(4)~~ (5) sanctions against facilities for failure to comply with reporting system  
192.29 requirements; and

192.30 ~~(5)~~ (6) communication from the commissioner to facilities, health care purchasers, and  
192.31 the public to maximize the use of the reporting system to improve health care quality.

193.1 (c) The commissioner is not authorized to select from or between competing alternate  
193.2 acceptable medical practices.

193.3 **EFFECTIVE DATE.** This section is effective October 1, 2025.

193.4 Sec. 96. Minnesota Statutes 2022, section 144.9501, subdivision 9, is amended to read:

193.5 Subd. 9. **Elevated blood lead level.** "Elevated blood lead level" means a diagnostic  
193.6 blood lead test with a result that is equal to or greater than ~~ten~~ 3.5 micrograms of lead per  
193.7 deciliter of whole blood in any person, unless the commissioner finds that a lower  
193.8 concentration is necessary to protect public health.

193.9 Sec. 97. Minnesota Statutes 2022, section 144.9501, subdivision 17, is amended to read:

193.10 Subd. 17. **Lead hazard reduction.** (a) "Lead hazard reduction" means abatement, swab  
193.11 team services, or interim controls undertaken to make a residence, child care facility, school,  
193.12 playground, or other location where lead hazards are identified lead-safe by complying with  
193.13 the lead standards and methods adopted under section 144.9508.

193.14 (b) Lead hazard reduction does not include renovation activity that is primarily intended  
193.15 to remodel, repair, or restore a given structure or dwelling rather than abate or control  
193.16 lead-based paint hazards.

193.17 (c) Lead hazard reduction does not include activities that disturb painted surfaces that  
193.18 total:

193.19 (1) less than 20 square feet (two square meters) on exterior surfaces; or

193.20 (2) less than two square feet (0.2 square meters) in an interior room.

193.21 Sec. 98. Minnesota Statutes 2022, section 144.9501, subdivision 26a, is amended to read:

193.22 Subd. 26a. **Regulated lead work.** ~~(a)~~ "Regulated lead work" means:

193.23 (1) abatement;

193.24 (2) interim controls;

193.25 (3) a clearance inspection;

193.26 (4) a lead hazard screen;

193.27 (5) a lead inspection;

193.28 (6) a lead risk assessment;

193.29 (7) lead project designer services;

194.1 (8) lead sampling technician services;

194.2 (9) swab team services;

194.3 (10) renovation activities; ~~or~~

194.4 (11) lead hazard reduction; or

194.5 ~~(11)~~ (12) activities performed to comply with lead orders issued by a community health  
194.6 ~~board~~ an assessing agency.

194.7 ~~(b) Regulated lead work does not include abatement, interim controls, swab team services,~~  
194.8 ~~or renovation activities that disturb painted surfaces that total no more than:~~

194.9 ~~(1) 20 square feet (two square meters) on exterior surfaces; or~~

194.10 ~~(2) six square feet (0.6 square meters) in an interior room.~~

194.11 Sec. 99. Minnesota Statutes 2022, section 144.9501, subdivision 26b, is amended to read:

194.12 Subd. 26b. **Renovation.** (a) "Renovation" means the modification of any pre-1978  
194.13 affected property for compensation that results in the disturbance of known or presumed  
194.14 lead-containing painted surfaces defined under section 144.9508, unless that activity is  
194.15 performed as lead hazard reduction. A renovation performed for the purpose of converting  
194.16 a building or part of a building into an affected property is a renovation under this  
194.17 subdivision.

194.18 (b) Renovation does not include minor repair and maintenance activities described in  
194.19 this paragraph. All activities that disturb painted surfaces and are performed within 30 days  
194.20 of other activities that disturb painted surfaces in the same room must be considered a single  
194.21 project when applying the criteria below. Unless the activity involves window replacement  
194.22 or demolition of a painted surface, building component, or portion of a structure, for purposes  
194.23 of this paragraph, "minor repair and maintenance" means activities that disturb painted  
194.24 surfaces totaling:

194.25 (1) less than 20 square feet (two square meters) on exterior surfaces; or

194.26 (2) less than six square feet (0.6 square meters) in an interior room.

194.27 (c) Renovation does not include total demolition of a freestanding structure. For purposes  
194.28 of this paragraph, "total demolition" means demolition and disposal of all interior and  
194.29 exterior painted surfaces, including windows. Unpainted foundation building components  
194.30 remaining after total demolition may be reused.

195.1 Sec. 100. Minnesota Statutes 2022, section 144.9501, is amended by adding a subdivision  
195.2 to read:

195.3 Subd. 33. **Compensation.** "Compensation" means money or other mutually agreed upon  
195.4 form of payment given or received for regulated lead work, including rental payments,  
195.5 rental income, or salaries derived from rental payments.

195.6 Sec. 101. Minnesota Statutes 2022, section 144.9501, is amended by adding a subdivision  
195.7 to read:

195.8 Subd. 34. **Individual.** "Individual" means a natural person.

195.9 Sec. 102. Minnesota Statutes 2022, section 144.9505, subdivision 1, is amended to read:

195.10 Subdivision 1. **Licensing, certification, and permitting.** (a) Fees collected under this  
195.11 section shall be deposited into the state treasury and credited to the state government special  
195.12 revenue fund.

195.13 (b) Persons shall not advertise or otherwise present themselves as lead supervisors, lead  
195.14 workers, lead inspectors, lead risk assessors, lead sampling technicians, lead project designers,  
195.15 renovation firms, or lead firms unless they have licenses or certificates issued by the  
195.16 commissioner under this section.

195.17 (c) The fees required in this section for inspectors, risk assessors, and certified lead firms  
195.18 are waived for state or local government employees performing services for or as an assessing  
195.19 agency.

195.20 (d) ~~An individual who is the owner of property on which regulated lead work is to be~~  
195.21 ~~performed or an adult individual who is related to the property owner, as defined under~~  
195.22 ~~section 245A.02, subdivision 13, is exempt from the requirements to obtain a license and~~  
195.23 ~~pay a fee according to this section.~~ Individual residential property owners who perform  
195.24 regulated lead work on their own residence are exempt from the licensure and firm  
195.25 certification requirements of this section. Notwithstanding the provisions of paragraphs (a)  
195.26 to (c), this exemption does not apply when the regulated lead work is a renovation performed  
195.27 for compensation, when a child with an elevated blood level has been identified in the  
195.28 residence or the building in which the residence is located, or when the residence is occupied  
195.29 by one or more individuals who are not related to the property owner, as defined under  
195.30 section 245A.02, subdivision 13.

195.31 (e) ~~A person that employs individuals to perform regulated lead work outside of the~~  
195.32 ~~person's property must obtain certification as a certified lead firm. An individual who~~

196.1 ~~performs lead hazard reduction, lead hazard screens, lead inspections, lead risk assessments,~~  
196.2 ~~clearance inspections, lead project designer services, lead sampling technician services,~~  
196.3 ~~swab team services, and activities performed to comply with lead orders must be employed~~  
196.4 ~~by a certified lead firm, unless the individual is a sole proprietor and does not employ any~~  
196.5 ~~other individuals, the individual is employed by a person that does not perform regulated~~  
196.6 ~~lead work outside of the person's property, or the individual is employed by an assessing~~  
196.7 ~~agency.~~

196.8 Sec. 103. Minnesota Statutes 2022, section 144.9505, subdivision 1g, is amended to read:

196.9 Subd. 1g. **Certified lead firm.** A person who performs or employs individuals to perform  
196.10 regulated lead work, with the exception of renovation, ~~outside of the person's property~~ must  
196.11 obtain certification as a lead firm. The certificate must be in writing, contain an expiration  
196.12 date, be signed by the commissioner, and give the name and address of the person to whom  
196.13 it is issued. A lead firm certificate is valid for one year. The certification fee is \$100, is  
196.14 nonrefundable, and must be submitted with each application. The lead firm certificate or a  
196.15 copy of the certificate must be readily available at the worksite for review by the contracting  
196.16 entity, the commissioner, and other public health officials charged with the health, safety,  
196.17 and welfare of the state's citizens.

196.18 Sec. 104. Minnesota Statutes 2022, section 144.9505, subdivision 1h, is amended to read:

196.19 Subd. 1h. **Certified renovation firm.** A person who performs or employs individuals  
196.20 to perform renovation ~~activities outside of the person's property~~ for compensation must  
196.21 obtain certification as a renovation firm. The certificate must be in writing, contain an  
196.22 expiration date, be signed by the commissioner, and give the name and address of the person  
196.23 to whom it is issued. A renovation firm certificate is valid for two years. The certification  
196.24 fee is \$100, is nonrefundable, and must be submitted with each application. The renovation  
196.25 firm certificate or a copy of the certificate must be readily available at the worksite for  
196.26 review by the contracting entity, the commissioner, and other public health officials charged  
196.27 with the health, safety, and welfare of the state's citizens.

196.28 Sec. 105. Minnesota Statutes 2022, section 144.9508, subdivision 2, is amended to read:

196.29 Subd. 2. **Regulated lead work standards and methods.** (a) The commissioner shall  
196.30 adopt rules establishing regulated lead work standards and methods in accordance with the  
196.31 provisions of this section, for lead in paint, dust, drinking water, and soil in a manner that  
196.32 protects public health and the environment for all residences, including residences also used  
196.33 for a commercial purpose, child care facilities, playgrounds, and schools.

197.1 (b) In the rules required by this section, the commissioner shall require lead hazard  
197.2 reduction of intact paint only if the commissioner finds that the intact paint is on a chewable  
197.3 or lead-dust producing surface that is a known source of actual lead exposure to a specific  
197.4 individual. The commissioner shall prohibit methods that disperse lead dust into the air that  
197.5 could accumulate to a level that would exceed the lead dust standard specified under this  
197.6 section. The commissioner shall work cooperatively with the commissioner of administration  
197.7 to determine which lead hazard reduction methods adopted under this section may be used  
197.8 for lead-safe practices including prohibited practices, preparation, disposal, and cleanup.  
197.9 The commissioner shall work cooperatively with the commissioner of the Pollution Control  
197.10 Agency to develop disposal procedures. In adopting rules under this section, the  
197.11 commissioner shall require the best available technology for regulated lead work methods,  
197.12 paint stabilization, and repainting.

197.13 (c) The commissioner of health shall adopt regulated lead work standards and methods  
197.14 for lead in bare soil in a manner to protect public health and the environment. The  
197.15 commissioner shall adopt a maximum standard of 100 parts of lead per million in bare soil.  
197.16 The commissioner shall set a soil replacement standard not to exceed 25 parts of lead per  
197.17 million. Soil lead hazard reduction methods shall focus on erosion control and covering of  
197.18 bare soil.

197.19 (d) The commissioner shall adopt regulated lead work standards and methods for lead  
197.20 in dust in a manner to protect the public health and environment. Dust standards shall use  
197.21 a weight of lead per area measure and include dust on the floor, on the window sills, and  
197.22 on window wells. Lead hazard reduction methods for dust shall focus on dust removal and  
197.23 other practices which minimize the formation of lead dust from paint, soil, or other sources.

197.24 (e) The commissioner shall adopt lead hazard reduction standards and methods for lead  
197.25 in drinking water both at the tap and public water supply system or private well in a manner  
197.26 to protect the public health and the environment. The commissioner may adopt the rules  
197.27 for controlling lead in drinking water as contained in Code of Federal Regulations, title 40,  
197.28 part 141. Drinking water lead hazard reduction methods may include an educational approach  
197.29 of minimizing lead exposure from lead in drinking water.

197.30 (f) The commissioner of the Pollution Control Agency shall adopt rules to ensure that  
197.31 removal of exterior lead-based coatings from residences and steel structures by abrasive  
197.32 blasting methods is conducted in a manner that protects health and the environment.

198.1 (g) All regulated lead work standards shall provide reasonable margins of safety that  
198.2 are consistent with more than a summary review of scientific evidence and an emphasis on  
198.3 overprotection rather than underprotection when the scientific evidence is ambiguous.

198.4 (h) No unit of local government shall have an ordinance or regulation governing regulated  
198.5 lead work standards or methods for lead in paint, dust, drinking water, or soil that require  
198.6 a different regulated lead work standard or method than the standards or methods established  
198.7 under this section.

198.8 (i) Notwithstanding paragraph (h), the commissioner may approve the use by a unit of  
198.9 local government of an innovative lead hazard reduction method which is consistent in  
198.10 approach with methods established under this section.

198.11 (j) The commissioner shall adopt rules for issuing lead orders required under section  
198.12 144.9504, rules for notification of abatement or interim control activities requirements, and  
198.13 other rules necessary to implement sections 144.9501 to 144.9512.

198.14 (k) The commissioner shall adopt rules consistent with section 402(c)(3) of the Toxic  
198.15 Substances Control Act and all regulations adopted thereunder to ensure that renovation in  
198.16 a pre-1978 affected property ~~where a child or pregnant female resides~~ is conducted in a  
198.17 manner that protects health and the environment. Notwithstanding sections 14.125 and  
198.18 14.128, the authority to adopt these rules does not expire.

198.19 (l) The commissioner shall adopt rules consistent with sections 406(a) and 406(b) of the  
198.20 Toxic Substances Control Act. Notwithstanding sections 14.125 and 14.128, the authority  
198.21 to adopt these rules does not expire.

198.22 Sec. 106. Minnesota Statutes 2022, section 144A.06, subdivision 2, is amended to read:

198.23 Subd. 2. **New license required; change of ownership.** (a) The commissioner of health  
198.24 by rule shall prescribe procedures for licensure under this section.

198.25 (b) A new license is required and the prospective licensee must apply for a license prior  
198.26 to operating a currently licensed nursing home. The licensee must change whenever one of  
198.27 the following events occur:

198.28 (1) the form of the licensee's legal entity structure is converted or changed to a different  
198.29 type of legal entity structure;

198.30 (2) the licensee dissolves, consolidates, or merges with another legal organization and  
198.31 the licensee's legal organization does not survive;

199.1 (3) within the previous 24 months, 50 percent or more of the licensee's ownership interest  
199.2 is transferred, whether by a single transaction or multiple transactions to:

199.3 (i) a different person or multiple different persons; or

199.4 (ii) a person or multiple persons who had less than a five percent ownership interest in  
199.5 the facility at the time of the first transaction; or

199.6 (4) any other event or combination of events that results in a substitution, elimination,  
199.7 or withdrawal of the licensee's responsibility for the facility.

199.8 Sec. 107. Minnesota Statutes 2022, section 144A.071, subdivision 2, is amended to read:

199.9 Subd. 2. **Moratorium.** (a) The commissioner of health, in coordination with the  
199.10 commissioner of human services, shall deny each request for new licensed or certified  
199.11 nursing home or certified boarding care beds except as provided in subdivision 3 or 4a, or  
199.12 section 144A.073. "Certified bed" means a nursing home bed or a boarding care bed certified  
199.13 by the commissioner of health for the purposes of the medical assistance program, under  
199.14 United States Code, title 42, sections 1396 et seq. Certified beds in facilities which do not  
199.15 allow medical assistance intake shall be deemed to be decertified for purposes of this section  
199.16 only.

199.17 (b) The commissioner of human services, in coordination with the commissioner of  
199.18 health, shall deny any request to issue a license under section 252.28 and chapter 245A to  
199.19 a nursing home or boarding care home, if that license would result in an increase in the  
199.20 medical assistance reimbursement amount.

199.21 (c) In addition, the commissioner of health must not approve any construction project  
199.22 whose cost exceeds \$1,000,000, unless:

199.23 ~~(a)~~ (1) any construction costs exceeding \$1,000,000 are not added to the facility's  
199.24 appraised value and are not included in the facility's payment rate for reimbursement under  
199.25 the medical assistance program; or

199.26 ~~(b)~~ (2) the project:

199.27 ~~(1)~~ (i) has been approved through the process described in section 144A.073;

199.28 ~~(2)~~ (ii) meets an exception in subdivision 3 or 4a;

199.29 ~~(3)~~ (iii) is necessary to correct violations of state or federal law issued by the  
199.30 commissioner of health;

200.1 ~~(4)~~ (iv) is necessary to repair or replace a portion of the facility that was damaged by  
200.2 fire, lightning, ground shifts, or other such hazards, including environmental hazards,  
200.3 provided that the provisions of subdivision 4a, clause (a), are met; or

200.4 ~~(5)~~ (v) is being proposed by a licensed nursing facility that is not certified to participate  
200.5 in the medical assistance program and will not result in new licensed or certified beds.

200.6 (d) Prior to the final plan approval of any construction project, the commissioners of  
200.7 health and human services shall be provided with an itemized cost estimate for the project  
200.8 construction costs. If a construction project is anticipated to be completed in phases, the  
200.9 total estimated cost of all phases of the project shall be submitted to the commissioners and  
200.10 shall be considered as one construction project. Once the construction project is completed  
200.11 and prior to the final clearance by the commissioners, the total project construction costs  
200.12 for the construction project shall be submitted to the commissioners. If the final project  
200.13 construction cost exceeds the dollar threshold in this subdivision, the commissioner of  
200.14 human services shall not recognize any of the project construction costs or the related  
200.15 financing costs in excess of this threshold in establishing the facility's property-related  
200.16 payment rate.

200.17 (e) The dollar thresholds for construction projects are as follows: for construction projects  
200.18 other than those authorized in ~~clauses (1) to (6)~~ paragraph (c), clause (2), items (i) to (v),  
200.19 the dollar threshold is \$1,000,000. For projects authorized after July 1, 1993, under ~~clause~~  
200.20 ~~(1)~~ paragraph (c), clause (2), item (i), the dollar threshold is the cost estimate submitted  
200.21 with a proposal for an exception under section 144A.073, plus inflation as calculated  
200.22 according to section 256B.431, subdivision 3f, paragraph (a). For projects authorized under  
200.23 ~~clauses (2) to (4)~~ paragraph (c), clause (2), items (ii) to (iv), the dollar threshold is the  
200.24 itemized estimate project construction costs submitted to the commissioner of health at the  
200.25 time of final plan approval, plus inflation as calculated according to section 256B.431,  
200.26 subdivision 3f, paragraph (a).

200.27 (f) The commissioner of health shall adopt rules to implement this section or to amend  
200.28 the emergency rules for granting exceptions to the moratorium on nursing homes under  
200.29 section 144A.073.

200.30 (g) All construction projects approved through section 144A.073, subdivision 3, after  
200.31 March 1, 2020, are subject to the fair rental value property rate as described in section  
200.32 256R.26.

200.33 **EFFECTIVE DATE.** This section is effective retroactively from March 1, 2020.

- 201.1 Sec. 108. Minnesota Statutes 2022, section 144A.073, subdivision 3b, is amended to read:
- 201.2 Subd. 3b. **Amendments to approved projects.** (a) Nursing facilities that have received
- 201.3 approval ~~on or after July 1, 1993,~~ for exceptions to the moratorium on nursing homes through
- 201.4 the process described in this section may request amendments to the designs of the projects
- 201.5 by writing the commissioner within 15 months of receiving approval. Applicants shall
- 201.6 submit supporting materials that demonstrate how the amended projects meet the criteria
- 201.7 described in paragraph (b).
- 201.8 (b) The commissioner shall approve requests for amendments for projects approved ~~on~~
- 201.9 ~~or after July 1, 1993,~~ according to the following criteria:
- 201.10 (1) the amended project designs must provide solutions to all of the problems addressed
- 201.11 by the original application that are at least as effective as the original solutions;
- 201.12 (2) the amended project designs may not reduce the space in each resident's living area
- 201.13 or in the total amount of common space devoted to resident and family uses by more than
- 201.14 five percent;
- 201.15 (3) the costs ~~recognized for reimbursement~~ of amended project designs shall be ~~the~~
- 201.16 ~~threshold amount of the original proposal as identified according to section 144A.071,~~
- 201.17 ~~subdivision 2~~ the cost estimate associated with the project as originally approved, except
- 201.18 under conditions described in clause (4); and
- 201.19 (4) total costs ~~up to ten percent greater than the cost identified in clause (3) may be~~
- 201.20 ~~recognized for reimbursement if~~ of the amendment are no greater than ten percent of the
- 201.21 cost estimate associated with the project as initially approved if the proposer can document
- 201.22 that one of the following circumstances is true:
- 201.23 (i) changes are needed due to a natural disaster;
- 201.24 (ii) conditions that affect the safety or durability of the project that could not have
- 201.25 reasonably been known prior to approval are discovered;
- 201.26 (iii) state or federal law require changes in project design; or
- 201.27 (iv) documentable circumstances occur that are beyond the control of the owner and
- 201.28 require changes in the design.
- 201.29 (c) Approval of a request for an amendment does not alter the expiration of approval of
- 201.30 the project according to subdivision 3.

202.1 (d) Reimbursement for amendments to approved projects is independent of the actual  
202.2 construction costs and based on the allowable appraised value of the completed project. An  
202.3 approved project may not be amended to reduce the scope of an approved project.

202.4 **EFFECTIVE DATE.** This section is effective retroactively from March 1, 2020.

202.5 Sec. 109. Minnesota Statutes 2022, section 144A.474, subdivision 3, is amended to read:

202.6 Subd. 3. **Survey process.** The survey process for core surveys shall include the following  
202.7 as applicable to the particular licensee and setting surveyed:

202.8 (1) presurvey review of pertinent documents and notification to the ombudsman for  
202.9 long-term care;

202.10 (2) an entrance conference with available staff;

202.11 (3) communication with managerial officials or the registered nurse in charge, if available,  
202.12 and ongoing communication with key staff throughout the survey regarding information  
202.13 needed by the surveyor, clarifications regarding home care requirements, and applicable  
202.14 standards of practice;

202.15 (4) presentation of written contact information to the provider about the survey staff  
202.16 conducting the survey, the supervisor, and the process for requesting a reconsideration of  
202.17 the survey results;

202.18 (5) a brief tour of ~~a sample of the housing with services establishments~~ establishment  
202.19 in which the provider is providing home care services;

202.20 (6) a sample selection of home care clients;

202.21 (7) information-gathering through client and staff observations, client and staff interviews,  
202.22 and reviews of records, policies, procedures, practices, and other agency information;

202.23 (8) interviews of clients' family members, if available, with clients' consent when the  
202.24 client can legally give consent;

202.25 (9) except for complaint surveys conducted by the Office of Health Facilities Complaints,  
202.26 an ~~on-site~~ exit conference; with preliminary findings ~~shared and~~ discussed with the provider  
202.27 within one business day after completion of survey activities, ~~documentation that an exit~~  
202.28 ~~conference occurred~~, and with written information provided on the process for requesting  
202.29 a reconsideration of the survey results; and

202.30 (10) postsurvey analysis of findings and formulation of survey results, including  
202.31 correction orders when applicable.

203.1 Sec. 110. Minnesota Statutes 2022, section 144A.474, subdivision 9, is amended to read:

203.2 Subd. 9. **Follow-up surveys.** For providers that have Level 3 or Level 4 violations under  
203.3 subdivision 11, ~~or any violations determined to be widespread,~~ the department shall conduct  
203.4 a follow-up survey within 90 calendar days of the survey. When conducting a follow-up  
203.5 survey, the surveyor will focus on whether the previous violations have been corrected and  
203.6 may also address any new violations that are observed while evaluating the corrections that  
203.7 have been made.

203.8 Sec. 111. Minnesota Statutes 2022, section 144A.474, subdivision 12, is amended to read:

203.9 Subd. 12. **Reconsideration.** (a) The commissioner shall make available to home care  
203.10 providers a correction order reconsideration process. This process may be used to challenge  
203.11 the correction order issued, including the level and scope described in subdivision 11, and  
203.12 any fine assessed. During the correction order reconsideration request, the issuance for the  
203.13 correction orders under reconsideration are not stayed, but the department shall post  
203.14 information on the website with the correction order that the licensee has requested a  
203.15 reconsideration and that the review is pending.

203.16 (b) A licensed home care provider may request from the commissioner, in writing, a  
203.17 correction order reconsideration regarding any correction order issued to the provider. The  
203.18 written request for reconsideration must be received by the commissioner within 15 ~~calendar~~  
203.19 business days of the correction order receipt date. The correction order reconsideration shall  
203.20 not be reviewed by any surveyor, investigator, or supervisor that participated in the writing  
203.21 or reviewing of the correction order being disputed. The correction order reconsiderations  
203.22 may be conducted in person, by telephone, by another electronic form, or in writing, as  
203.23 determined by the commissioner. The commissioner shall respond in writing to the request  
203.24 from a home care provider for a correction order reconsideration within 60 days of the date  
203.25 the provider requests a reconsideration. The commissioner's response shall identify the  
203.26 commissioner's decision regarding each citation challenged by the home care provider.

203.27 (c) The findings of a correction order reconsideration process shall be one or more of  
203.28 the following:

203.29 (1) supported in full, the correction order is supported in full, with no deletion of findings  
203.30 to the citation;

203.31 (2) supported in substance, the correction order is supported, but one or more findings  
203.32 are deleted or modified without any change in the citation;

204.1 (3) correction order cited an incorrect home care licensing requirement, the correction  
204.2 order is amended by changing the correction order to the appropriate statutory reference;

204.3 (4) correction order was issued under an incorrect citation, the correction order is amended  
204.4 to be issued under the more appropriate correction order citation;

204.5 (5) the correction order is rescinded;

204.6 (6) fine is amended, it is determined that the fine assigned to the correction order was  
204.7 applied incorrectly; or

204.8 (7) the level or scope of the citation is modified based on the reconsideration.

204.9 (d) If the correction order findings are changed by the commissioner, the commissioner  
204.10 shall update the correction order website.

204.11 (e) This subdivision does not apply to temporary licensees.

204.12 Sec. 112. Minnesota Statutes 2022, section 144A.4791, subdivision 10, is amended to  
204.13 read:

204.14 Subd. 10. **Termination of service plan.** (a) If a home care provider terminates a service  
204.15 plan with a client, and the client continues to need home care services, the home care provider  
204.16 shall provide the client and the client's representative, if any, with a written notice of  
204.17 termination which includes the following information:

204.18 (1) the effective date of termination;

204.19 (2) the reason for termination;

204.20 (3) a statement that the client may contact the Office of Ombudsman for Long-Term  
204.21 Care to request an advocate to assist regarding the termination and contact information for  
204.22 the office, including the office's central telephone number;

204.23 ~~(3)~~ (4) a list of known licensed home care providers in the client's immediate geographic  
204.24 area;

204.25 ~~(4)~~ (5) a statement that the home care provider will participate in a coordinated transfer  
204.26 of care of the client to another home care provider, health care provider, or caregiver, as  
204.27 required by the home care bill of rights, section 144A.44, subdivision 1, clause (17);

204.28 ~~(5)~~ (6) the name and contact information of a person employed by the home care provider  
204.29 with whom the client may discuss the notice of termination; and

205.1 ~~(6)~~ (7) if applicable, a statement that the notice of termination of home care services  
205.2 does not constitute notice of termination of ~~the housing with services contract with a housing~~  
205.3 ~~with services establishment~~ any housing contract.

205.4 (b) When the home care provider voluntarily discontinues services to all clients, the  
205.5 home care provider must notify the commissioner, lead agencies, and ombudsman for  
205.6 long-term care about its clients and comply with the requirements in this subdivision.

205.7 Sec. 113. Minnesota Statutes 2022, section 144G.16, subdivision 7, is amended to read:

205.8 Subd. 7. **Fines and penalties.** (a) The fee ~~fine~~ for failure to comply with the notification  
205.9 requirements in section 144G.52, subdivision 7, is \$1,000.

205.10 (b) Fines and penalties collected under this section shall be deposited in a dedicated  
205.11 special revenue account. On an annual basis, the balance in the special revenue account  
205.12 shall be appropriated to the commissioner to implement the recommendations of the advisory  
205.13 council established in section 144A.4799.

205.14 Sec. 114. Minnesota Statutes 2022, section 144G.18, is amended to read:

205.15 **144G.18 NOTIFICATION OF CHANGES IN INFORMATION.**

205.16 Subdivision 1. Notification. A provisional licensee or licensee shall notify the  
205.17 commissioner in writing prior to a change in the manager or authorized agent and within  
205.18 60 calendar days after any change in the information required in section 144G.12, subdivision  
205.19 1, clause (1), (3), (4), (17), or (18).

205.20 Subd. 2. **Fines and penalties.** (a) The fine for failure to comply with the notification  
205.21 requirements of this section is \$1,000.

205.22 (b) Fines and penalties collected under this subdivision shall be deposited in a dedicated  
205.23 special revenue account. On an annual basis, the balance in the special revenue account  
205.24 shall be appropriated to the commissioner to implement the recommendations of the advisory  
205.25 council established in section 144A.4799.

205.26 Sec. 115. Minnesota Statutes 2022, section 144G.57, subdivision 8, is amended to read:

205.27 Subd. 8. **~~Fine~~ Fines and penalties.** (a) The commissioner may impose a fine for failure  
205.28 to follow the requirements of this section.

205.29 (b) The fine for failure to comply with this section is \$1,000.

206.1 (c) Fines and penalties collected under this section shall be deposited in a dedicated  
206.2 special revenue account. On an annual basis, the balance in the special revenue account  
206.3 shall be appropriated to the commissioner to implement the recommendations of the advisory  
206.4 council established in section 144A.4799.

206.5 Sec. 116. Minnesota Statutes 2022, section 145.411, subdivision 1, is amended to read:

206.6 Subdivision 1. **Terms.** As used in sections 145.411 to ~~145.416~~ 145.414, the terms defined  
206.7 in this section have the meanings given to them.

206.8 **EFFECTIVE DATE.** This section is effective the day following final enactment.

206.9 Sec. 117. Minnesota Statutes 2022, section 145.411, subdivision 5, is amended to read:

206.10 Subd. 5. **Abortion.** "Abortion" includes an act, procedure or use of any instrument,  
206.11 medicine or drug which is supplied or prescribed for or administered to ~~a pregnant woman~~  
206.12 an individual with the intention of terminating, and which results in the termination of,  
206.13 pregnancy.

206.14 **EFFECTIVE DATE.** This section is effective the day following final enactment.

206.15 Sec. 118. Minnesota Statutes 2022, section 145.423, subdivision 1, is amended to read:

206.16 Subdivision 1. **Recognition; ~~medical care.~~** ~~A born alive~~ An infant as a result of an  
206.17 abortion who is born alive shall be fully recognized as a human person, and accorded  
206.18 immediate protection under the law. All reasonable measures consistent with good medical  
206.19 practice, including the compilation of appropriate medical records, shall be taken by the  
206.20 responsible medical personnel to ~~preserve the life and health of the born alive infant~~ care  
206.21 for the infant who is born alive.

206.22 **EFFECTIVE DATE.** This section is effective the day following final enactment.

206.23 Sec. 119. **[145.561] 988 SUICIDE AND CRISIS LIFELINE.**

206.24 Subdivision 1. **Definitions.** (a) For the purposes of this section, the following have the  
206.25 meanings given.

206.26 (b) "Commissioner" means the commissioner of health.

206.27 (c) "Department" means the Department of Health.

206.28 (d) "988" means the universal telephone number designated as the universal telephone  
206.29 number within the United States for the purpose of the national suicide prevention and

207.1 mental health crisis hotline system operating through the 988 Suicide and Crisis Lifeline,  
207.2 or its successor, maintained by the Assistant Secretary for Mental Health and Substance  
207.3 Use under section 520E-3 of the Public Health Service Act (United States Code, title 42,  
207.4 sections 290bb-36c).

207.5 (e) "988 administrator" means the administrator of the national 988 Suicide and Crisis  
207.6 Lifeline maintained by the Assistant Secretary for Mental Health and Substance Use under  
207.7 section 520E-3 of the Public Health Service Act.

207.8 (f) "988 contact" means a communication with the 988 Suicide and Crisis Lifeline system  
207.9 within the United States via modalities offered including call, chat, or text.

207.10 (g) "988 Lifeline Center" means a state-identified center that is a member of the Suicide  
207.11 and Crisis Lifeline network that responds to statewide or regional 988 contacts.

207.12 (h) "988 Suicide and Crisis Lifeline" or "988 Lifeline" means the national suicide  
207.13 prevention and mental health crisis hotline system maintained by the Assistant Secretary  
207.14 for Mental Health and Substance Use under section 520E-3 of the Public Health Service  
207.15 Act (United States Code, title 42, sections 290bb-36c).

207.16 (i) "Veterans Crisis Line" means the Veterans Crisis Line maintained by the Secretary  
207.17 of Veterans Affairs under United States Code, title 38, section 170F(h).

207.18 Subd. 2. **988 Lifeline.** (a) The commissioner shall administer the designation of and  
207.19 oversight for a 988 Lifeline center or a network of 988 Lifeline centers to answer contacts  
207.20 from individuals accessing the Suicide and Crisis Lifeline from any jurisdiction within the  
207.21 state 24 hours per day, seven days per week.

207.22 (b) The designated 988 Lifeline Center must:

207.23 (1) have an active agreement with the 988 Suicide and Crisis Lifeline program for  
207.24 participation in the network and the department;

207.25 (2) meet the 988 Lifeline program requirements and best practice guidelines for  
207.26 operational and clinical standards;

207.27 (3) provide data and reports, and participate in evaluations and related quality  
207.28 improvement activities as required by the 988 Lifeline program and the department;

207.29 (4) identify or adapt technology that is demonstrated to be interoperable across Mobile  
207.30 Crisis and Public Safety Answering Points used in the state for the purpose of crisis care  
207.31 coordination;

208.1 (5) facilitate crisis and outgoing services, including mobile crisis teams in accordance  
208.2 with guidelines established by the 988 Lifeline program and the department;

208.3 (6) actively collaborate and coordinate service linkages with mental health and substance  
208.4 use disorder treatment providers, local community mental health centers including certified  
208.5 community behavioral health clinics and community behavioral health centers, mobile crisis  
208.6 teams, and community based and hospital emergency departments;

208.7 (7) offer follow-up services to individuals accessing the 988 Lifeline Center that are  
208.8 consistent with guidance established by the 988 Lifeline program and the department; and

208.9 (8) meet the requirements set by the 988 Lifeline program and the department for serving  
208.10 at-risk and specialized populations.

208.11 (c) The department shall adopt rules and regulations to allow appropriate information  
208.12 sharing and communication between and across crisis and emergency response systems.

208.13 (d) The department, having primary oversight of suicide prevention, shall work with the  
208.14 988 Lifeline program, veterans crisis line, and other SAMHSA-approved networks for the  
208.15 purpose of ensuring consistency of public messaging about 988 services. The department  
208.16 may use funds under this section or provide grants to organizations in order to publicize  
208.17 and raise awareness about 988 services.

208.18 (e) The department shall work with representatives from 988 Lifeline Centers and public  
208.19 safety answering points, other public safety agencies, and the commissioner of public safety  
208.20 to facilitate the development of protocols and procedures for interactions between 988 and  
208.21 911 services across Minnesota. Protocols and procedures shall be developed following  
208.22 available national standards and guidelines.

208.23 (f) The department shall provide an annual report of the 988 Lifeline usage including  
208.24 answer rates, abandoned calls, and referrals to 911 emergency response.

208.25 **Subd. 3. 988 special revenue account established.** (a) There is established a dedicated  
208.26 account in the special revenue fund to create and maintain a statewide 988 suicide and crisis  
208.27 lifeline system pursuant to the National Suicide Hotline Designation Act of 2020, the Federal  
208.28 Communications Commission's rules adopted July 16, 2020, and national guidelines for  
208.29 crisis care.

208.30 (b) The account shall consist of:

208.31 (1) a 988 telecommunications fee imposed under this section;

208.32 (2) a prepaid wireless 988 fee imposed under section 403.161;

- 209.1 (3) appropriations made by the state legislature;
- 209.2 (4) grants and gifts intended for deposit;
- 209.3 (5) interest, premiums, gains, or other earnings on the account; and
- 209.4 (6) money from any other source that is deposited in or transferred to the account.
- 209.5 (c) The account shall be administered by the department, and money in the account shall
- 209.6 be expended to offset costs that are or can be reasonably attributed to:
- 209.7 (1) implementing, maintaining, and improving the 988 suicide and crisis lifeline including
- 209.8 staffing and technological infrastructure enhancements necessary to achieve operational
- 209.9 standards and best practices set by the 988 lifeline and the department;
- 209.10 (2) personnel for 988 lifeline centers;
- 209.11 (3) data collection, reporting, participation in evaluations, public promotion, and related
- 209.12 quality improvement activities as required by the 988 administrator and the department;
- 209.13 and
- 209.14 (4) administration, oversight, and evaluation of the account.
- 209.15 (d) Money in the fund:
- 209.16 (1) does not revert at the end of any state fiscal year but remains available for the purposes
- 209.17 of the account in subsequent state fiscal years;
- 209.18 (2) is not subject to transfer to any other fund or to transfer, assignment, or reassignment
- 209.19 for any other use or purpose; and
- 209.20 (3) is continuously appropriated to the commissioner for the purposes of the account.
- 209.21 (e) An annual report of funds, deposits, and expenditures shall be made to the Federal
- 209.22 Communications Commission.
- 209.23 Subd. 4. **988 telecommunication fee.** (a) In compliance with the National Suicide Hotline
- 209.24 Designation Act of 2020, the department shall impose a monthly statewide fee on each
- 209.25 subscriber of a wireline, wireless, and IP-enabled voice service at a rate that provides for
- 209.26 the robust creation, operation, and maintenance of a statewide 988 suicide prevention and
- 209.27 crisis system.
- 209.28 (b) The commissioner shall annually recommend to the Public Utilities Commission an
- 209.29 adequate and appropriate fee to implement this section. The commissioner shall provide
- 209.30 telecommunication service providers and carriers a minimum of 30 days' notice of each fee
- 209.31 change.

210.1 (c) The amount of the 988 telecommunication fee must not be less than 12 cents and no  
210.2 more than 25 cents a month on or after January 1, 2024, for each consumer access line,  
210.3 including trunk equivalents as designated by the commission pursuant to section 403.11,  
210.4 subdivision 1. The 988 telecommunication fee must be the same for all subscribers.

210.5 (d) Each wireline, wireless, and IP-enabled voice telecommunications service provider  
210.6 shall collect the 988 telecommunication fee and transfer the amounts collected to the  
210.7 commissioner of public safety in the same manner as provided in section 403.11, subdivision  
210.8 1, paragraph (d).

210.9 (e) The commissioner of public safety shall deposit the money collected from the 988  
210.10 telecommunication fee to the 988 account to be expended only in support of 988 services,  
210.11 or enhancements of such services.

210.12 (f) Consistent with United States Code, title 47, section 251(a), the revenue generated  
210.13 by a 988 telecommunication fee must only be used to offset costs that are or will be  
210.14 reasonably attributed to:

210.15 (1) ensuring the efficient and effective routing and handling of calls, chats, and texts  
210.16 made to the 988 Lifeline centers including staffing and technological infrastructure  
210.17 enhancements necessary to achieve operational, performance, and clinical standards and  
210.18 best practices set by the 988 Lifeline program and the department; and

210.19 (2) personnel and providing acute mental health and crisis outreach services by directly  
210.20 responding to the 988 Suicide and Crisis Lifeline.

210.21 (g) All 988 telecommunication fee revenue must be used to supplement, not supplant,  
210.22 any federal, state, or local funding for suicide prevention.

210.23 (h) The 988 telecommunication fee amount shall be adjusted as needed to provide for  
210.24 continuous operation, volume increases, and maintenance of the 988 service.

210.25 (i) The commissioner shall report on revenue generated by the 988 telecommunication  
210.26 fee to the Federal Communications Commission.

210.27 Subd. 5. **988 fee for prepaid wireless telecommunications services.** (a) The 988  
210.28 telecommunication fee established in subdivision 4 does not apply to prepaid wireless  
210.29 telecommunications services. Prepaid wireless telecommunications services are subject to  
210.30 the prepaid wireless 988 fee established in section 403.161, subdivision 1, paragraph (c).

210.31 (b) Collection, remittance, and deposit of prepaid wireless 988 fees are governed by  
210.32 sections 403.161 and 403.162.

211.1 Sec. 120. Minnesota Statutes 2022, section 145.87, subdivision 4, is amended to read:

211.2 Subd. 4. ~~Administrative costs~~ Administration. The commissioner may use up to seven  
211.3 percent of the annual appropriation under this section to provide training and technical  
211.4 assistance and to administer and evaluate the program. The commissioner may contract for  
211.5 training, capacity-building support for grantees or potential grantees, technical assistance,  
211.6 and evaluation support.

211.7 Sec. 121. [145.875] HOME VISITING FOR PRIORITY POPULATIONS.

211.8 Subdivision 1. Establishment; priority populations. The commissioner of health shall  
211.9 administer a program to expand home visiting services for priority populations. The  
211.10 commissioner shall determine priority populations based on the most recent maternal and  
211.11 child health data, including the statewide Maternal, Infant, and Early Childhood Home  
211.12 Visiting needs assessment.

211.13 Subd. 2. Grants. The commissioner shall award competitive grants under this section  
211.14 to community health boards, Tribal governments, and nonprofit organizations. Grant funds  
211.15 must be used to start up or expand home visiting programs in the county, reservation, or  
211.16 region to serve families in priority populations. Grant recipients must prioritize provision  
211.17 of services to priority populations such as parents at high risk or with high needs, parents  
211.18 with a history of mental illness, domestic abuse, or substance abuse, children with special  
211.19 health care needs, and families experiencing or at risk for homelessness. Priority for grants  
211.20 may be given to programs enrolling families with a child aged two to four years old.

211.21 Subd. 3. Technical assistance and evaluation. The commissioner shall provide technical  
211.22 assistance and training to grant recipients on promising practices and shall evaluate results.

211.23 Sec. 122. [145.903] SCHOOL-BASED HEALTH CENTERS.

211.24 Subdivision 1. Definitions. (a) For purposes of this section, the following terms have  
211.25 the meanings given.

211.26 (b) "School-based health center" or "comprehensive school-based health center" means  
211.27 a safety net health care delivery model that is located in or near a school facility and that  
211.28 offers comprehensive health care, including preventive and behavioral health services,  
211.29 provided by licensed and qualified health professionals in accordance with federal, state,  
211.30 and local law. When not located on school property, the school-based health center must  
211.31 have an established relationship with one or more schools in the community and operate to  
211.32 primarily serve those student groups.

- 212.1 (c) "Sponsoring organization" means any of the following that operate a school-based  
212.2 health center:
- 212.3 (1) health care providers;  
212.4 (2) community clinics;  
212.5 (3) hospitals;  
212.6 (4) federally qualified health centers and look-alikes as defined in section 145.9269;  
212.7 (5) health care foundations or nonprofit organizations;  
212.8 (6) higher education institutions; or  
212.9 (7) local health departments.
- 212.10 Subd. 2. **Expansion of Minnesota school-based health centers.** (a) The commissioner  
212.11 of health shall administer a program to provide grants to school districts and school-based  
212.12 health centers to support existing centers and facilitate the growth of school-based health  
212.13 centers in Minnesota.
- 212.14 (b) Grant funds distributed under this subdivision shall be used to support new or existing  
212.15 school-based health centers that:
- 212.16 (1) operate in partnership with a school or school district and with the permission of the  
212.17 school or school district board;  
212.18 (2) provide health services through a sponsoring organization; and  
212.19 (3) provide health services to all students and youth within a school or school district,  
212.20 regardless of ability to pay, insurance coverage, or immigration status, and in accordance  
212.21 with federal, state, and local law.
- 212.22 (c) The commissioner of health shall administer a grant to a nonprofit organization to  
212.23 facilitate a community of practice among school-based health centers to improve quality,  
212.24 equity, and sustainability of care delivered through school-based health centers; encourage  
212.25 cross-sharing among school-based health centers; support existing clinics; and expand  
212.26 school-based health centers in new communities in Minnesota.
- 212.27 (d) Grant recipients shall report their activities and annual performance measures as  
212.28 defined by the commissioner in a format and time specified by the commissioner.
- 212.29 (e) The commissioners of health and of education shall coordinate the projects and  
212.30 initiatives funded under this section with other efforts at the local, state, or national level  
212.31 to avoid duplication and promote coordinated efforts.

213.1 Subd. 3. School-based health center services. Services provided by a school-based  
 213.2 health center may include but are not limited to:

213.3 (1) preventive health care;

213.4 (2) chronic medical condition management, including diabetes and asthma care;

213.5 (3) mental health care and crisis management;

213.6 (4) acute care for illness and injury;

213.7 (5) oral health care;

213.8 (6) vision care;

213.9 (7) nutritional counseling;

213.10 (8) substance abuse counseling;

213.11 (9) referral to a specialist, medical home, or hospital for care;

213.12 (10) additional services that address social determinants of health; and

213.13 (11) emerging services such as mobile health and telehealth.

213.14 Subd. 4. Sponsoring organizations. A sponsoring organization that agrees to operate  
 213.15 a school-based health center must enter into a memorandum of agreement with the school  
 213.16 or school district. The memorandum of agreement must require the sponsoring organization  
 213.17 to be financially responsible for the operation of school-based health centers in the school  
 213.18 or school district and must identify the costs that are the responsibility of the school or  
 213.19 school district, such as Internet access, custodial services, utilities, and facility maintenance.  
 213.20 To the greatest extent possible, a sponsoring organization must bill private insurers, medical  
 213.21 assistance, and other public programs for services provided in the school-based health  
 213.22 centers in order to maintain the financial sustainability of school-based health centers.

213.23 Sec. 123. Minnesota Statutes 2022, section 145.924, is amended to read:

213.24 **145.924 AIDS HIV PREVENTION GRANTS.**

213.25 (a) The commissioner may award grants to community health boards as defined in section  
 213.26 145A.02, subdivision 5, state agencies, state councils, or nonprofit corporations to provide  
 213.27 evaluation and counseling services to populations at risk for acquiring human  
 213.28 immunodeficiency virus infection, including, but not limited to, ~~minorities~~ communities of  
 213.29 color, adolescents, intravenous drug users women, people who inject drugs, and homosexual  
 213.30 men gay, bisexual, and transgender individuals.

214.1 (b) The commissioner may award grants to agencies experienced in providing services  
 214.2 to communities of color, for the design of innovative outreach and education programs for  
 214.3 targeted groups within the community who may be at risk of acquiring the human  
 214.4 immunodeficiency virus infection, including ~~intravenous drug users~~ people who inject drugs  
 214.5 and their partners, adolescents, women, and gay ~~and~~, bisexual, and transgender individuals  
 214.6 ~~and women~~. Grants shall be awarded on a request for proposal basis and shall include funds  
 214.7 for administrative costs. Priority for grants shall be given to agencies or organizations that  
 214.8 have experience in providing service to the particular community which the grantee proposes  
 214.9 to serve; that have policy makers representative of the targeted population; that have  
 214.10 experience in dealing with issues relating to HIV/AIDS; and that have the capacity to deal  
 214.11 effectively with persons of differing sexual orientations. For purposes of this paragraph,  
 214.12 the "communities of color" are: the American-Indian community; the Hispanic community;  
 214.13 the African-American community; and the Asian-Pacific Islander community.

214.14 (c) All state grants awarded under this section for programs targeted to adolescents shall  
 214.15 include the promotion of abstinence from sexual activity and drug use.

214.16 (d) The commissioner shall administer a grant program to provide funds to organizations,  
 214.17 including Tribal health agencies, to assist with HIV/AIDS outbreaks.

214.18 Sec. 124. Minnesota Statutes 2022, section 145.925, is amended to read:

214.19 **145.925 FAMILY PLANNING SEXUAL AND REPRODUCTIVE HEALTH**  
 214.20 **SERVICES GRANTS.**

214.21 Subdivision 1. ~~Eligible organizations; purpose~~ **Goal and establishment.** ~~The~~  
 214.22 ~~commissioner of health may make special grants to cities, counties, groups of cities or~~  
 214.23 ~~counties, or nonprofit corporations to provide pre-pregnancy family planning services. (a)~~  
 214.24 It is the goal of the state to increase access to sexual and reproductive health services for  
 214.25 people who experience barriers, whether geographic, cultural, financial, or other, in access  
 214.26 to such services. The commissioner of health shall administer grants to facilitate access to  
 214.27 sexual and reproductive health services for people of reproductive age, particularly those  
 214.28 from populations that experience barriers to these services.

214.29 (b) The commissioner of health shall coordinate with other efforts at the local, state, or  
 214.30 national level to avoid duplication and promote complementary efforts in sexual and  
 214.31 reproductive health service promotion among people of reproductive age.

214.32 ~~Subd. 1a. Family planning services; defined.~~ "Family planning services" means  
 214.33 ~~counseling by trained personnel regarding family planning; distribution of information~~

215.1 ~~relating to family planning, referral to licensed physicians or local health agencies for~~  
215.2 ~~consultation, examination, medical treatment, genetic counseling, and prescriptions for the~~  
215.3 ~~purpose of family planning; and the distribution of family planning products, such as charts,~~  
215.4 ~~thermometers, drugs, medical preparations, and contraceptive devices. For purposes of~~  
215.5 ~~sections 145A.01 to 145A.14, family planning shall mean voluntary action by individuals~~  
215.6 ~~to prevent or aid conception but does not include the performance, or make referrals for~~  
215.7 ~~encouragement of voluntary termination of pregnancy.~~

215.8 ~~Subd. 2. **Prohibition.** The commissioner shall not make special grants pursuant to this~~  
215.9 ~~section to any nonprofit corporation which performs abortions. No state funds shall be used~~  
215.10 ~~under contract from a grantee to any nonprofit corporation which performs abortions. This~~  
215.11 ~~provision shall not apply to hospitals licensed pursuant to sections 144.50 to 144.56, or~~  
215.12 ~~health maintenance organizations certified pursuant to chapter 62D.~~

215.13 Subd. 2a. **Sexual and reproductive health services defined.** For purposes of this section,  
215.14 "sexual and reproductive health services" means services that promote a state of complete  
215.15 physical, mental, and social well-being in relation to sexuality and reproduction, and not  
215.16 merely the absence of disease or infirmity, in all matters relating to the reproductive system  
215.17 and its functions and processes, and to sexuality. These services must be provided in accord  
215.18 with nationally recognized standards and include but are not limited to sexual and  
215.19 reproductive health counseling, voluntary and informed decision-making on sexual and  
215.20 reproductive health, information on and provision of contraceptive methods, sexual and  
215.21 reproductive health screenings and treatment, pregnancy testing and counseling, and other  
215.22 preconception services.

215.23 ~~Subd. 3. **Minors Grants authorized.** No funds provided by grants made pursuant to~~  
215.24 ~~this section shall be used to support any family planning services for any unemancipated~~  
215.25 ~~minor in any elementary or secondary school building. (a) The commissioner of health shall~~  
215.26 ~~award grants to eligible community organizations, including nonprofit organizations,~~  
215.27 ~~community health boards, and Tribal communities in rural and metropolitan areas of the~~  
215.28 ~~state to support, sustain, expand, or implement reproductive and sexual health programs for~~  
215.29 ~~people of reproductive age to increase access to and availability of medically accurate sexual~~  
215.30 ~~and reproductive health services.~~

215.31 (b) The commissioner of health shall establish application scoring criteria in the evaluation  
215.32 of applications submitted for award under this section. These criteria shall include but are  
215.33 not limited to the degree to which applicants' programming responds to demographic factors  
215.34 relevant to subdivision 1, paragraph (a), and paragraph (f).

216.1 (c) When determining whether to award a grant or the amount of a grant under this  
216.2 section, the commissioner of health may identify and stratify geographic regions based on  
216.3 the region's need for sexual and reproductive health services. In this stratification, the  
216.4 commissioner may consider data on the prevalence of poverty and other factors relevant to  
216.5 a geographic region's need for sexual and reproductive health services.

216.6 (d) The commissioner of health may consider geographic and Tribal communities'  
216.7 representation in the award of grants.

216.8 (e) Current recipients of funding under this section shall not be afforded priority over  
216.9 new applicants.

216.10 (f) Grant funds shall be used to support new or existing sexual and reproductive health  
216.11 programs that provide person-centered, accessible services; that are culturally and  
216.12 linguistically appropriate, inclusive of all people, and trauma-informed; that protect the  
216.13 dignity of the individual; and that ensure equitable, quality services consistent with nationally  
216.14 recognized standards of care. These services shall include:

216.15 (1) education and outreach on medically accurate sexual and reproductive health  
216.16 information;

216.17 (2) contraceptive counseling, provision of contraceptive methods, and follow-up;

216.18 (3) screening, testing, and treatment of sexually transmitted infections and other sexual  
216.19 or reproductive concerns; and

216.20 (4) referral and follow-up for medical, financial, mental health, and other services in  
216.21 accord with a service recipient's needs.

216.22 ~~Subd. 4. **Parental notification.** Except as provided in sections 144.341 and 144.342,~~  
216.23 ~~any person employed to provide family planning services who is paid in whole or in part~~  
216.24 ~~from funds provided under this section who advises an abortion or sterilization to any~~  
216.25 ~~unemancipated minor shall, following such a recommendation, so notify the parent or~~  
216.26 ~~guardian of the reasons for such an action.~~

216.27 ~~Subd. 5. **Rules.** The commissioner of health shall promulgate rules for approval of plans~~  
216.28 ~~and budgets of prospective grant recipients, for the submission of annual financial and~~  
216.29 ~~statistical reports, and the maintenance of statements of source and application of funds by~~  
216.30 ~~grant recipients. The commissioner of health may not require that any home rule charter or~~  
216.31 ~~statutory city or county apply for or receive grants under this subdivision as a condition for~~  
216.32 ~~the receipt of any state or federal funds unrelated to family planning services.~~

217.1 Subd. 6. **Public services; individual ~~and employee rights~~.** The request of any person  
 217.2 for ~~family planning~~ sexual and reproductive health services or the refusal to accept any  
 217.3 service shall in no way affect the right of the person to receive public assistance, public  
 217.4 health services, or any other public service. Nothing in this section shall abridge the right  
 217.5 of the ~~individual~~ person to make decisions concerning ~~family planning~~ sexual and  
 217.6 reproductive health, nor shall any ~~individual~~ person be required to state a reason for refusing  
 217.7 any offer of ~~family planning~~ sexual and reproductive health services.

217.8 ~~Any employee of the agencies engaged in the administration of the provisions of this~~  
 217.9 ~~section may refuse to accept the duty of offering family planning services to the extent that~~  
 217.10 ~~the duty is contrary to personal beliefs. A refusal shall not be grounds for dismissal,~~  
 217.11 ~~suspension, demotion, or any other discrimination in employment. The directors or~~  
 217.12 ~~supervisors of the agencies shall reassign the duties of employees in order to carry out the~~  
 217.13 ~~provisions of this section.~~

217.14 All information gathered by any agency, entity, or individual conducting programs in  
 217.15 ~~family planning~~ sexual and reproductive health is private data on individuals within the  
 217.16 meaning of section 13.02, subdivision 12. For any person or entity meeting the definition  
 217.17 of a "provider" under section 144.291, subdivision 2, paragraph (i), all sexual and  
 217.18 reproductive health services information provided to, gathered about, or received from a  
 217.19 person under this section is also subject to the Minnesota Health Records Act, in sections  
 217.20 144.291 to 144.298.

217.21 Subd. 7. **Family planning services; information required.** A grant recipient shall  
 217.22 ~~inform any person requesting counseling on family planning methods or procedures of:~~

217.23 ~~(1) Any methods or procedures which may be followed, including identification of any~~  
 217.24 ~~which are experimental or any which may pose a health hazard to the person;~~

217.25 ~~(2) A description of any attendant discomforts or risks which might reasonably be~~  
 217.26 ~~expected;~~

217.27 ~~(3) A fair explanation of the likely results, should a method fail;~~

217.28 ~~(4) A description of any benefits which might reasonably be expected of any method;~~

217.29 ~~(5) A disclosure of appropriate alternative methods or procedures;~~

217.30 ~~(6) An offer to answer any inquiries concerning methods or procedures; and~~

217.31 ~~(7) An instruction that the person is free either to decline commencement of any method~~  
 217.32 ~~or procedure or to withdraw consent to a method or procedure at any reasonable time.~~

218.1 ~~Subd. 8. **Coercion; penalty.** Any person who receives compensation for services under~~  
218.2 ~~any program receiving financial assistance under this section, who coerces or endeavors to~~  
218.3 ~~coerce any person to undergo an abortion or sterilization procedure by threatening the person~~  
218.4 ~~with the loss of or disqualification for the receipt of any benefit or service under a program~~  
218.5 ~~receiving state or federal financial assistance shall be guilty of a misdemeanor.~~

218.6 ~~Subd. 9. **Amount of grant; rules.** Notwithstanding any rules to the contrary, including~~  
218.7 ~~rules proposed in the State Register on April 1, 1991, the commissioner, in allocating grant~~  
218.8 ~~funds for family planning special projects, shall not limit the total amount of funds that can~~  
218.9 ~~be allocated to an organization. The commissioner shall allocate to an organization receiving~~  
218.10 ~~grant funds on July 1, 1997, at least the same amount of grant funds for the 1998 to 1999~~  
218.11 ~~grant cycle as the organization received for the 1996 to 1997 grant cycle, provided the~~  
218.12 ~~organization submits an application that meets grant funding criteria. This subdivision does~~  
218.13 ~~not affect any procedure established in rule for allocating special project money to the~~  
218.14 ~~different regions. The commissioner shall revise the rules for family planning special project~~  
218.15 ~~grants so that they conform to the requirements of this subdivision. In adopting these~~  
218.16 ~~revisions, the commissioner is not subject to the rulemaking provisions of chapter 14, but~~  
218.17 ~~is bound by section 14.386, paragraph (a), clauses (1) and (3). Section 14.386, paragraph~~  
218.18 ~~(b), does not apply to these rules.~~

218.19 **Sec. 125. [145.9257] COMMUNITY SOLUTIONS FOR HEALTHY CHILD**  
218.20 **DEVELOPMENT GRANT PROGRAM.**

218.21 Subdivision 1. **Establishment.** The commissioner of health shall establish a grant  
218.22 program to improve child development outcomes and the well-being of children of color  
218.23 and American Indian children from prenatal to grade 3 and their families. The purposes of  
218.24 the program are to:

218.25 (1) improve child development outcomes related to the well-being of children of color  
218.26 and American Indian children from prenatal to grade 3 and their families, including but not  
218.27 limited to the goals outlined by the Department of Human Services' early childhood systems  
218.28 reform effort: early learning; health and well-being; economic security; and safe, stable,  
218.29 nurturing relationships and environments by funding community-based solutions for  
218.30 challenges that are identified by the affected community;

218.31 (2) reduce racial disparities in children's health and development from prenatal to grade  
218.32 3; and

218.33 (3) promote racial and geographic equity.

- 219.1 Subd. 2. Commissioner's duties. The commissioner of health shall:
- 219.2 (1) develop a request for proposals for the community solutions healthy child development
- 219.3 grant program in consultation with the community solutions advisory council;
- 219.4 (2) provide outreach, technical assistance, and program development support to increase
- 219.5 capacity for new and existing service providers in order to better meet statewide needs,
- 219.6 particularly in greater Minnesota and areas where services to reduce health disparities have
- 219.7 not been established;
- 219.8 (3) review responses to requests for proposals, in consultation with the community
- 219.9 solutions advisory council, and award grants under this section;
- 219.10 (4) ensure communication with the ethnic councils, Minnesota Indian Affairs Council,
- 219.11 and the State Advisory Council on Early Childhood Education and Care on the request for
- 219.12 proposal process;
- 219.13 (5) establish a transparent and objective accountability process, in consultation with the
- 219.14 community solutions advisory council, focused on outcomes that grantees agree to achieve;
- 219.15 (6) provide grantees with access to data to assist grantees in establishing and
- 219.16 implementing effective community-led solutions;
- 219.17 (7) maintain data on outcomes reported by grantees; and
- 219.18 (8) contract with an independent third-party entity to evaluate the success of the grant
- 219.19 program and to build the evidence base for effective community solutions in reducing health
- 219.20 disparities of children of color and American Indian children from prenatal to grade 3.
- 219.21 Subd. 3. Community solutions advisory council; establishment; duties;
- 219.22 compensation. (a) No later than October 1, 2023, the commissioner shall have convened
- 219.23 a 12-member community solutions advisory council as follows:
- 219.24 (1) two members representing the African Heritage community;
- 219.25 (2) two members representing the Latino community;
- 219.26 (3) two members representing the Asian-Pacific Islander community;
- 219.27 (4) two members representing the American Indian community;
- 219.28 (5) two parents of children who are under nine years of age and are Black, nonwhite
- 219.29 people of color, or American Indian;
- 219.30 (6) one member with research or academic expertise in racial equity and healthy child
- 219.31 development; and

220.1 (7) one member representing an organization that advocates on behalf of communities  
220.2 of color or American Indians.

220.3 (b) At least three of the 12 members of the advisory council must come from outside  
220.4 the seven-county metropolitan area.

220.5 (c) The community solutions advisory council shall:

220.6 (1) advise the commissioner on the development of the request for proposals for  
220.7 community solutions healthy child development grants. In advising the commissioner, the  
220.8 council must consider how to build on the capacity of communities to promote child and  
220.9 family well-being and address social determinants of healthy child development;

220.10 (2) review responses to requests for proposals and advise the commissioner on the  
220.11 selection of grantees and grant awards;

220.12 (3) advise the commissioner on the establishment of a transparent and objective  
220.13 accountability process focused on outcomes the grantees agree to achieve;

220.14 (4) advise the commissioner on ongoing oversight and necessary support in the  
220.15 implementation of the program; and

220.16 (5) support the commissioner on other racial equity and early childhood grant efforts.

220.17 (d) Each advisory council member shall be compensated in accordance with section  
220.18 15.059, subdivision 3.

220.19 Subd. 4. **Eligible grantees.** Organizations eligible to receive grant funding under this  
220.20 section include: (1) organizations or entities that work with Black, non-white communities  
220.21 of color, and American Indian communities;

220.22 (2) Tribal nations and Tribal organizations as defined in section 658P of the Child Care  
220.23 and Development Block Grant Act of 1990; and

220.24 (3) organizations or entities focused on supporting healthy child development.

220.25 Subd. 5. **Strategic consideration and priority of proposals; eligible populations;**  
220.26 **grant awards.** (a) The commissioner, in consultation with the community solutions advisory  
220.27 council, shall develop a request for proposals for healthy child development grants. In  
220.28 developing the proposals and awarding the grants, the commissioner shall consider building  
220.29 on the capacity of communities to promote child and family well-being and address social  
220.30 determinants of healthy child development. Proposals must focus on increasing racial equity  
220.31 and healthy child development and reducing health disparities experienced by children who

221.1 are Black, nonwhite people of color, or American Indian from prenatal to grade 3 and their  
221.2 families.

221.3 (b) In awarding the grants, the commissioner shall provide strategic consideration and  
221.4 give priority to proposals from:

221.5 (1) organizations or entities led by Black and other nonwhite people of color and serving  
221.6 Black and nonwhite communities of color;

221.7 (2) organizations or entities led by American Indians and serving American Indians,  
221.8 including Tribal nations and Tribal organizations;

221.9 (3) organizations or entities with proposals focused on healthy development from prenatal  
221.10 to grade three;

221.11 (4) organizations or entities with proposals focusing on multigenerational solutions;

221.12 (5) organizations or entities located in or with proposals to serve communities located  
221.13 in counties that are moderate to high risk according to the Wilder Research Risk and Reach  
221.14 Report; and

221.15 (6) community-based organizations that have historically served communities of color  
221.16 and American Indians and have not traditionally had access to state grant funding.

221.17 The advisory council may recommend additional strategic considerations and priorities  
221.18 to the commissioner.

221.19 Subd. 6. **Geographic distribution of grants.** The commissioner and the advisory council  
221.20 shall ensure that grant funds are prioritized and awarded to organizations and entities that  
221.21 are within counties that have a higher proportion of Black, nonwhite communities of color,  
221.22 and American Indians than the state average, to the extent possible.

221.23 Subd. 7. **Report.** Grantees must report grant program outcomes to the commissioner on  
221.24 the forms and according to the timelines established by the commissioner.

221.25 Sec. 126. **[145.9272] LEAD REMEDIATION IN SCHOOL AND CHILD CARE**  
221.26 **SETTINGS GRANT PROGRAM.**

221.27 Subdivision 1. **Establishment; purpose.** The commissioner of health shall develop a  
221.28 grant program for the purpose of remediating identified sources of lead in drinking water  
221.29 in schools and licensed child care settings.

221.30 Subd. 2. **Grants authorized.** The commissioner shall award grants through a request  
221.31 for proposals process to schools and licensed child care settings. Priority shall be given to

222.1 schools and licensed child care settings with higher levels of lead detected in water samples,  
222.2 evidence of lead service lines, or lead plumbing materials and school districts that serve  
222.3 disadvantaged communities.

222.4 Subd. 3. **Grant allocation.** Grantees must use the funds to address sources of lead  
222.5 contamination in their facilities including but not limited to service connections and premise  
222.6 plumbing, and to implement best practices for water management within the building.

222.7 Sec. 127. **[145.9273] TESTING FOR LEAD IN DRINKING WATER IN CHILD**  
222.8 **CARE SETTINGS.**

222.9 Subdivision 1. **Requirement to test.** By July 1, 2024, licensed child care providers must  
222.10 develop a plan to accurately and efficiently test for the presence of lead in drinking water  
222.11 in child care facilities following either the Department of Health's document "Reducing  
222.12 Lead in Drinking Water: A Technical Guidance for Minnesota's School and Child Care  
222.13 Facilities" or the Environmental Protection Agency's "3Ts: Training, Testing, Taking Action"  
222.14 guidance materials.

222.15 Subd. 2. **Scope and frequency of testing.** The plan under subdivision 1 must include  
222.16 testing every building serving children and all water fixtures used for consumption of water,  
222.17 including water used in food preparation. All taps must be tested at least once every five  
222.18 years. A licensed child care provider must begin testing in buildings by July 1, 2024, and  
222.19 complete testing in all buildings that serve students within five years.

222.20 Subd. 3. **Remediation of lead in drinking water.** The plan under subdivision 1 must  
222.21 include steps to remediate if lead is present in drinking water. A licensed child care provider  
222.22 that finds lead at concentrations at or exceeding five parts per billion at a specific location  
222.23 providing water to children within its facilities must take action to reduce lead exposure  
222.24 following guidance and verify the success of remediation by retesting the location for lead.  
222.25 Remediation actions are actions that reduce lead levels from the drinking water fixture as  
222.26 demonstrated by testing. This includes using certified filters, implementing, and documenting  
222.27 a building-wide flushing program, and replacing or removing fixtures with elevated lead  
222.28 levels.

222.29 Subd. 4. **Reporting results.** (a) A licensed child care provider that tested its buildings  
222.30 for the presence of lead shall make the results of the testing and any remediation steps taken  
222.31 available to parents and staff and notify them of the availability of results. Reporting shall  
222.32 occur no later than 30 days from receipt of results and annually thereafter.

223.1 (b) Beginning July 1, 2024, a licensed child care provider must report the provider's test  
223.2 results and remediation activities to the commissioner of health annually on or before July  
223.3 1 of each year.

223.4 Sec. 128. **[145.987] HEALTH EQUITY ADVISORY AND LEADERSHIP (HEAL)**  
223.5 **COUNCIL.**

223.6 Subdivision 1. **Establishment; composition of advisory council.** The commissioner  
223.7 shall establish and appoint a health equity advisory and leadership (HEAL) council to  
223.8 provide guidance to the commissioner of health regarding strengthening and improving the  
223.9 health of communities most impacted by health inequities across the state. The council shall  
223.10 consist of 18 members who will provide representation from the following groups:

223.11 (1) African American and African heritage communities;

223.12 (2) Asian American and Pacific Islander communities;

223.13 (3) Latina/o/x communities;

223.14 (4) American Indian communities and Tribal governments and nations;

223.15 (5) disability communities;

223.16 (6) lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities; and

223.17 (7) representatives who reside outside the seven-county metropolitan area.

223.18 Subd. 2. **Organization and meetings.** The advisory council shall be organized and  
223.19 administered under section 15.059. Meetings shall be held at least quarterly and hosted by  
223.20 the department. Subcommittees may be convened as necessary. Advisory council meetings  
223.21 are subject to the open meeting law under chapter 13D.

223.22 Subd. 3. **Duties.** The advisory council shall:

223.23 (1) advise the commissioner on health equity issues and the health equity priorities and  
223.24 concerns of the populations specified in subdivision 1;

223.25 (2) assist the agency in efforts to advance health equity, including consulting on specific  
223.26 agency policies and programs, providing ideas and input about potential budget and policy  
223.27 proposals, and recommending review of agency policies, standards, or procedures that may  
223.28 create or perpetuate health inequities; and

223.29 (3) assist the agency in developing and monitoring meaningful performance measures  
223.30 related to advancing health equity.

224.1 Subd. 4. **Expiration.** The advisory council shall remain in existence until health inequities  
224.2 in the state are eliminated. Health inequities will be considered eliminated when race,  
224.3 ethnicity, income, gender, gender identity, geographic location, or other identity or social  
224.4 marker will no longer be predictors of health outcomes in the state. Section 145.928 describes  
224.5 nine health disparities that must be considered when determining whether health inequities  
224.6 have been eliminated in the state.

224.7 Sec. 129. Minnesota Statutes 2022, section 145A.131, subdivision 1, is amended to read:

224.8 Subdivision 1. **Funding formula for community health boards.** (a) Base funding for  
224.9 each community health board eligible for a local public health grant under section 145A.03,  
224.10 subdivision 7, shall be determined by each community health board's fiscal year 2003  
224.11 allocations, prior to unallotment, for the following grant programs: community health  
224.12 services subsidy; state and federal maternal and child health special projects grants; family  
224.13 home visiting grants; TANF MN ENABL grants; TANF youth risk behavior grants; and  
224.14 available women, infants, and children grant funds in fiscal year 2003, prior to unallotment,  
224.15 distributed based on the proportion of WIC participants served in fiscal year 2003 within  
224.16 the CHS service area.

224.17 (b) Base funding for a community health board eligible for a local public health grant  
224.18 under section 145A.03, subdivision 7, as determined in paragraph (a), shall be adjusted by  
224.19 the percentage difference between the base, as calculated in paragraph (a), and the funding  
224.20 available for the local public health grant.

224.21 (c) Multicounty or multicity community health boards shall receive a local partnership  
224.22 base of up to \$5,000 per year for each county or city in the case of a multicity community  
224.23 health board included in the community health board.

224.24 (d) The State Community Health Advisory Committee may recommend a formula to  
224.25 the commissioner to use in distributing funds to community health boards.

224.26 (e) Notwithstanding any adjustment in paragraph (b), community health boards, all or  
224.27 a portion of which are located outside of the counties of Anoka, Chisago, Carver, Dakota,  
224.28 Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright, are eligible to receive  
224.29 an increase equal to ten percent of the grant award to the community health board under  
224.30 paragraph (a) starting July 1, 2015. The increase in calendar year 2015 shall be prorated for  
224.31 the last six months of the year. For calendar years beginning on or after January 1, 2016,  
224.32 the amount distributed under this paragraph shall be adjusted each year based on available  
224.33 funding and the number of eligible community health boards.

225.1 (f) Funding for foundational public health responsibilities must be distributed based on  
225.2 a formula determined by the commissioner in consultation with the State Community Health  
225.3 Services Advisory Committee. A portion of these funds may be used to fund new  
225.4 organizational models, including multijurisdictional and regional partnerships. These funds  
225.5 shall be used in accordance with subdivision 5.

225.6 Sec. 130. Minnesota Statutes 2022, section 145A.131, subdivision 5, is amended to read:

225.7 Subd. 5. **Use of funds.** (a) Community health boards may use the base funding of their  
225.8 local public health grant funds as outlined in subdivision 1, paragraphs (a) to (e), to address  
225.9 the areas of public health responsibility and local priorities developed through the community  
225.10 health assessment and community health improvement planning process.

225.11 (b) Funding for foundational public health responsibilities as outlined in subdivision 1,  
225.12 paragraph (f), must be used to fulfill foundational public health responsibilities as defined  
225.13 by the commissioner in consultation with the State Community Health Services Advisory  
225.14 Committee unless a community health board can demonstrate fulfillment of foundational  
225.15 public health responsibilities. If a community health board can demonstrate foundational  
225.16 public health responsibilities are fulfilled, funds may be used for local priorities developed  
225.17 through the community health assessment and community health improvement planning  
225.18 process.

225.19 (c) By July 1, 2028, all local public health grant funds must be used first to fulfill  
225.20 foundational public health responsibilities. Once a community health board can demonstrate  
225.21 foundational public health responsibilities are fulfilled, funds can be used for local priorities  
225.22 developed through the community health assessment and community health improvement  
225.23 planning process.

225.24 Sec. 131. Minnesota Statutes 2022, section 145A.14, is amended by adding a subdivision  
225.25 to read:

225.26 Subd. 2b. **Grants to Tribes.** The commissioner shall distribute grants to Tribal  
225.27 governments for foundational public health responsibilities as defined by each Tribal  
225.28 government.

225.29 Sec. 132. Minnesota Statutes 2022, section 147A.08, is amended to read:

225.30 **147A.08 EXEMPTIONS.**

225.31 (a) This chapter does not apply to, control, prevent, or restrict the practice, service, or  
225.32 activities of persons listed in section 147.09, clauses (1) to (6) and (8) to (13);<sub>2</sub> persons

226.1 regulated under section 214.01, subdivision 2; or ~~persons~~ midlevel practitioners, nurses,  
226.2 or nurse-midwives as defined in section 144.1501, subdivision 1, paragraphs (i), (k), and  
226.3 (l).

226.4 (b) Nothing in this chapter shall be construed to require licensure of:

226.5 (1) a physician assistant student enrolled in a physician assistant educational program  
226.6 accredited by the Accreditation Review Commission on Education for the Physician Assistant  
226.7 or by its successor agency approved by the board;

226.8 (2) a physician assistant employed in the service of the federal government while  
226.9 performing duties incident to that employment; or

226.10 (3) technicians, other assistants, or employees of physicians who perform delegated  
226.11 tasks in the office of a physician but who do not identify themselves as a physician assistant.

226.12 Sec. 133. Minnesota Statutes 2022, section 148.261, subdivision 1, is amended to read:

226.13 Subdivision 1. **Grounds listed.** The board may deny, revoke, suspend, limit, or condition  
226.14 the license and registration of any person to practice advanced practice, professional, or  
226.15 practical nursing under sections 148.171 to 148.285, or to otherwise discipline a licensee  
226.16 or applicant as described in section 148.262. The following are grounds for disciplinary  
226.17 action:

226.18 (1) Failure to demonstrate the qualifications or satisfy the requirements for a license  
226.19 contained in sections 148.171 to 148.285 or rules of the board. In the case of a person  
226.20 applying for a license, the burden of proof is upon the applicant to demonstrate the  
226.21 qualifications or satisfaction of the requirements.

226.22 (2) Employing fraud or deceit in procuring or attempting to procure a permit, license,  
226.23 or registration certificate to practice advanced practice, professional, or practical nursing  
226.24 or attempting to subvert the licensing examination process. Conduct that subverts or attempts  
226.25 to subvert the licensing examination process includes, but is not limited to:

226.26 (i) conduct that violates the security of the examination materials, such as removing  
226.27 examination materials from the examination room or having unauthorized possession of  
226.28 any portion of a future, current, or previously administered licensing examination;

226.29 (ii) conduct that violates the standard of test administration, such as communicating with  
226.30 another examinee during administration of the examination, copying another examinee's  
226.31 answers, permitting another examinee to copy one's answers, or possessing unauthorized  
226.32 materials; or

227.1 (iii) impersonating an examinee or permitting an impersonator to take the examination  
227.2 on one's own behalf.

227.3 (3) Conviction of a felony or gross misdemeanor reasonably related to the practice of  
227.4 professional, advanced practice registered, or practical nursing. Conviction as used in this  
227.5 subdivision includes a conviction of an offense that if committed in this state would be  
227.6 considered a felony or gross misdemeanor without regard to its designation elsewhere, or  
227.7 a criminal proceeding where a finding or verdict of guilt is made or returned but the  
227.8 adjudication of guilt is either withheld or not entered.

227.9 (4) Revocation, suspension, limitation, conditioning, or other disciplinary action against  
227.10 the person's professional or practical nursing license or advanced practice registered nursing  
227.11 credential, in another state, territory, or country; failure to report to the board that charges  
227.12 regarding the person's nursing license or other credential are pending in another state,  
227.13 territory, or country; or having been refused a license or other credential by another state,  
227.14 territory, or country.

227.15 (5) Failure to or inability to perform professional or practical nursing as defined in section  
227.16 148.171, subdivision 14 or 15, with reasonable skill and safety, including failure of a  
227.17 registered nurse to supervise or a licensed practical nurse to monitor adequately the  
227.18 performance of acts by any person working at the nurse's direction.

227.19 (6) Engaging in unprofessional conduct, including, but not limited to, a departure from  
227.20 or failure to conform to board rules of professional or practical nursing practice that interpret  
227.21 the statutory definition of professional or practical nursing as well as provide criteria for  
227.22 violations of the statutes, or, if no rule exists, to the minimal standards of acceptable and  
227.23 prevailing professional or practical nursing practice, or any nursing practice that may create  
227.24 unnecessary danger to a patient's life, health, or safety. Actual injury to a patient need not  
227.25 be established under this clause.

227.26 (7) Failure of an advanced practice registered nurse to practice with reasonable skill and  
227.27 safety or departure from or failure to conform to standards of acceptable and prevailing  
227.28 advanced practice registered nursing.

227.29 (8) Delegating or accepting the delegation of a nursing function or a prescribed health  
227.30 care function when the delegation or acceptance could reasonably be expected to result in  
227.31 unsafe or ineffective patient care.

227.32 (9) Actual or potential inability to practice nursing with reasonable skill and safety to  
227.33 patients by reason of illness, use of alcohol, drugs, chemicals, or any other material, or as  
227.34 a result of any mental or physical condition.

228.1 (10) Adjudication as mentally incompetent, mentally ill, a chemically dependent person,  
228.2 or a person dangerous to the public by a court of competent jurisdiction, within or without  
228.3 this state.

228.4 (11) Engaging in any unethical conduct, including, but not limited to, conduct likely to  
228.5 deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for  
228.6 the health, welfare, or safety of a patient. Actual injury need not be established under this  
228.7 clause.

228.8 (12) Engaging in conduct with a patient that is sexual or may reasonably be interpreted  
228.9 by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning  
228.10 to a patient, or engaging in sexual exploitation of a patient or former patient.

228.11 (13) Obtaining money, property, or services from a patient, other than reasonable fees  
228.12 for services provided to the patient, through the use of undue influence, harassment, duress,  
228.13 deception, or fraud.

228.14 (14) Revealing a privileged communication from or relating to a patient except when  
228.15 otherwise required or permitted by law.

228.16 (15) Engaging in abusive or fraudulent billing practices, including violations of federal  
228.17 Medicare and Medicaid laws or state medical assistance laws.

228.18 (16) Improper management of patient records, including failure to maintain adequate  
228.19 patient records, to comply with a patient's request made pursuant to sections 144.291 to  
228.20 144.298, or to furnish a patient record or report required by law.

228.21 (17) Knowingly aiding, assisting, advising, or allowing an unlicensed person to engage  
228.22 in the unlawful practice of advanced practice, professional, or practical nursing.

228.23 (18) Violating a rule adopted by the board, an order of the board, or a state or federal  
228.24 law relating to the practice of advanced practice, professional, or practical nursing, or a  
228.25 state or federal narcotics or controlled substance law.

228.26 (19) Knowingly providing false or misleading information that is directly related to the  
228.27 care of that patient unless done for an accepted therapeutic purpose such as the administration  
228.28 of a placebo.

228.29 (20) Aiding suicide or aiding attempted suicide in violation of section 609.215 as  
228.30 established by any of the following:

228.31 (i) a copy of the record of criminal conviction or plea of guilty for a felony in violation  
228.32 of section 609.215, subdivision 1 or 2;

229.1 (ii) a copy of the record of a judgment of contempt of court for violating an injunction  
229.2 issued under section 609.215, subdivision 4;

229.3 (iii) a copy of the record of a judgment assessing damages under section 609.215,  
229.4 subdivision 5; or

229.5 (iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2.  
229.6 The board shall investigate any complaint of a violation of section 609.215, subdivision 1  
229.7 or 2.

229.8 (21) Practicing outside the scope of practice authorized by section 148.171, subdivision  
229.9 5, 10, 11, 13, 14, 15, or 21.

229.10 (22) Making a false statement or knowingly providing false information to the board,  
229.11 failing to make reports as required by section 148.263, or failing to cooperate with an  
229.12 investigation of the board as required by section 148.265.

229.13 (23) Engaging in false, fraudulent, deceptive, or misleading advertising.

229.14 (24) Failure to inform the board of the person's certification or recertification status as  
229.15 a certified registered nurse anesthetist, certified nurse-midwife, certified nurse practitioner,  
229.16 or certified clinical nurse specialist.

229.17 (25) Engaging in clinical nurse specialist practice, nurse-midwife practice, nurse  
229.18 practitioner practice, or registered nurse anesthetist practice without a license and current  
229.19 certification or recertification by a national nurse certification organization acceptable to  
229.20 the board.

229.21 ~~(26) Engaging in conduct that is prohibited under section 145.412.~~

229.22 ~~(27)~~ (26) Failing to report employment to the board as required by section 148.211,  
229.23 subdivision 2a, or knowingly aiding, assisting, advising, or allowing a person to fail to report  
229.24 as required by section 148.211, subdivision 2a.

229.25 **EFFECTIVE DATE.** This section is effective the day following final enactment.

229.26 Sec. 134. Minnesota Statutes 2022, section 148.512, subdivision 10a, is amended to read:

229.27 Subd. 10a. **Hearing aid.** "Hearing aid" means ~~an instrument~~ a prescribed aid, or any of  
229.28 its parts, worn in the ear canal and designed to or represented as being able to aid ~~or enhance~~  
229.29 human hearing. "Hearing aid" includes the aid's parts, attachments, or accessories, including,  
229.30 but not limited to, ear molds and behind the ear (BTE) devices with or without an ear mold.  
229.31 Batteries and cords are not parts, attachments, or accessories of a hearing aid. Surgically

230.1 implanted hearing aids, and assistive listening devices not worn within the ear canal, are  
230.2 not hearing aids.

230.3 Sec. 135. Minnesota Statutes 2022, section 148.512, subdivision 10b, is amended to read:

230.4 Subd. 10b. **Hearing aid dispensing.** "Hearing aid dispensing" means making ear mold  
230.5 impressions, prescribing, ~~or recommending~~ a hearing aid, assisting the consumer in  
230.6 prescription aid selection, selling hearing aids at retail, or testing human hearing in connection  
230.7 with these activities regardless of whether the person conducting these activities has a  
230.8 monetary interest in the dispensing of prescription hearing aids to the consumer. Hearing  
230.9 aid dispensing does not include selling over-the-counter hearing aids.

230.10 Sec. 136. Minnesota Statutes 2022, section 148.512, is amended by adding a subdivision  
230.11 to read:

230.12 Subd. 10c. **Over-the-counter hearing aid or OTC hearing aid.** "Over-the-counter  
230.13 hearing aid" or "OTC hearing aid" has the meaning given to that term in Code of Federal  
230.14 Regulations, title 21, section 800.30(b).

230.15 Sec. 137. Minnesota Statutes 2022, section 148.512, is amended by adding a subdivision  
230.16 to read:

230.17 Subd. 13a. **Prescription hearing aid.** "Prescription hearing aid" means a hearing aid  
230.18 requiring a prescription from a certified hearing aid dispenser or licensed audiologist that  
230.19 is not an OTC hearing aid.

230.20 Sec. 138. Minnesota Statutes 2022, section 148.513, is amended by adding a subdivision  
230.21 to read:

230.22 Subd. 4. **Over-the-counter hearing aids.** Nothing in sections 148.511 to 148.5198 shall  
230.23 preclude licensed audiologists from dispensing or selling over-the-counter hearing aids.

230.24 Sec. 139. Minnesota Statutes 2022, section 148.515, subdivision 6, is amended to read:

230.25 Subd. 6. **Dispensing audiologist examination requirements.** (a) Audiologists are  
230.26 exempt from the written examination requirement in section 153A.14, subdivision 2h,  
230.27 paragraph (a), clause (1).

230.28 (b) After July 31, 2005, all applicants for audiologist licensure under sections 148.512  
230.29 to 148.5198 must achieve a passing score on the practical tests of proficiency described in

231.1 section 153A.14, subdivision 2h, paragraph (a), clause (2), within the time period described  
231.2 in section 153A.14, subdivision 2h, paragraph (c).

231.3 (c) In order to dispense prescription hearing aids as a sole proprietor, member of a  
231.4 partnership, or for a limited liability company, corporation, or any other entity organized  
231.5 for profit, a licensee who obtained audiologist licensure under sections 148.512 to 148.5198,  
231.6 before August 1, 2005, and who is not certified to dispense prescription hearing aids under  
231.7 chapter 153A, must achieve a passing score on the practical tests of proficiency described  
231.8 in section 153A.14, subdivision 2h, paragraph (a), clause (2), within the time period described  
231.9 in section 153A.14, subdivision 2h, paragraph (c). All other audiologist licensees who  
231.10 obtained licensure before August 1, 2005, are exempt from the practical tests.

231.11 (d) An applicant for an audiology license who obtains a temporary license under section  
231.12 148.5175 may dispense prescription hearing aids only under supervision of a licensed  
231.13 audiologist who dispenses prescription hearing aids.

231.14 Sec. 140. Minnesota Statutes 2022, section 148.5175, is amended to read:

231.15 **148.5175 TEMPORARY LICENSURE.**

231.16 (a) The commissioner shall issue temporary licensure as a speech-language pathologist,  
231.17 an audiologist, or both, to an applicant who:

231.18 (1) submits a signed and dated affidavit stating that the applicant is not the subject of a  
231.19 disciplinary action or past disciplinary action in this or another jurisdiction and is not  
231.20 disqualified on the basis of section 148.5195, subdivision 3; and

231.21 (2) either:

231.22 (i) provides a copy of a current credential as a speech-language pathologist, an audiologist,  
231.23 or both, held in the District of Columbia or a state or territory of the United States; or

231.24 (ii) provides a copy of a current certificate of clinical competence issued by the American  
231.25 Speech-Language-Hearing Association or board certification in audiology by the American  
231.26 Board of Audiology.

231.27 (b) A temporary license issued to a person under this subdivision expires 90 days after  
231.28 it is issued or on the date the commissioner grants or denies licensure, whichever occurs  
231.29 first.

231.30 (c) Upon application, a temporary license shall be renewed twice to a person who is able  
231.31 to demonstrate good cause for failure to meet the requirements for licensure within the  
231.32 initial temporary licensure period and who is not the subject of a disciplinary action or

232.1 disqualified on the basis of section 148.5195, subdivision 3. Good cause includes but is not  
232.2 limited to inability to take and complete the required practical exam for dispensing  
232.3 prescription hearing instruments aids.

232.4 (d) Upon application, a temporary license shall be issued to a person who meets the  
232.5 requirements of section 148.515, subdivisions 2a and 4, but has not completed the  
232.6 requirement in section 148.515, subdivision 6.

232.7 Sec. 141. Minnesota Statutes 2022, section 148.5195, subdivision 3, is amended to read:

232.8 Subd. 3. **Grounds for disciplinary action by commissioner.** The commissioner may  
232.9 take any of the disciplinary actions listed in subdivision 4 on proof that the individual has:

232.10 (1) intentionally submitted false or misleading information to the commissioner or the  
232.11 advisory council;

232.12 (2) failed, within 30 days, to provide information in response to a written request by the  
232.13 commissioner or advisory council;

232.14 (3) performed services of a speech-language pathologist or audiologist in an incompetent  
232.15 or negligent manner;

232.16 (4) violated sections 148.511 to 148.5198;

232.17 (5) failed to perform services with reasonable judgment, skill, or safety due to the use  
232.18 of alcohol or drugs, or other physical or mental impairment;

232.19 (6) violated any state or federal law, rule, or regulation, and the violation is a felony or  
232.20 misdemeanor, an essential element of which is dishonesty, or which relates directly or  
232.21 indirectly to the practice of speech-language pathology or audiology. Conviction for violating  
232.22 any state or federal law which relates to speech-language pathology or audiology is  
232.23 necessarily considered to constitute a violation, except as provided in chapter 364;

232.24 (7) aided or abetted another person in violating any provision of sections 148.511 to  
232.25 148.5198;

232.26 (8) been or is being disciplined by another jurisdiction, if any of the grounds for the  
232.27 discipline is the same or substantially equivalent to those under sections 148.511 to 148.5198;

232.28 (9) not cooperated with the commissioner or advisory council in an investigation  
232.29 conducted according to subdivision 1;

232.30 (10) advertised in a manner that is false or misleading;

- 233.1 (11) engaged in conduct likely to deceive, defraud, or harm the public; or demonstrated  
233.2 a willful or careless disregard for the health, welfare, or safety of a client;
- 233.3 (12) failed to disclose to the consumer any fee splitting or any promise to pay a portion  
233.4 of a fee to any other professional other than a fee for services rendered by the other  
233.5 professional to the client;
- 233.6 (13) engaged in abusive or fraudulent billing practices, including violations of federal  
233.7 Medicare and Medicaid laws, Food and Drug Administration regulations, or state medical  
233.8 assistance laws;
- 233.9 (14) obtained money, property, or services from a consumer through the use of undue  
233.10 influence, high pressure sales tactics, harassment, duress, deception, or fraud;
- 233.11 (15) performed services for a client who had no possibility of benefiting from the services;
- 233.12 (16) failed to refer a client for medical evaluation or to other health care professionals  
233.13 when appropriate or when a client indicated symptoms associated with diseases that could  
233.14 be medically or surgically treated;
- 233.15 (17) had the certification required by chapter 153A denied, suspended, or revoked  
233.16 according to chapter 153A;
- 233.17 (18) used the term doctor of audiology, doctor of speech-language pathology, AuD, or  
233.18 SLPD without having obtained the degree from an institution accredited by the North Central  
233.19 Association of Colleges and Secondary Schools, the Council on Academic Accreditation  
233.20 in Audiology and Speech-Language Pathology, the United States Department of Education,  
233.21 or an equivalent;
- 233.22 (19) failed to comply with the requirements of section 148.5192 regarding supervision  
233.23 of speech-language pathology assistants; or
- 233.24 (20) if the individual is an audiologist or certified hearing ~~instrument~~ aid dispenser:
- 233.25 (i) ~~prescribed or otherwise recommended~~ to a consumer or potential consumer the use  
233.26 of a prescription hearing instrument aid, unless the prescription from a physician ~~or~~  
233.27 ~~recommendation from~~ an audiologist, or a certified dispenser is in writing, is based on an  
233.28 audiogram that is delivered to the consumer or potential consumer when the prescription  
233.29 ~~or recommendation~~ is made, and bears the following information in all capital letters of  
233.30 12-point or larger boldface type: "THIS PRESCRIPTION ~~OR RECOMMENDATION~~  
233.31 MAY BE FILLED BY, AND PRESCRIPTION HEARING INSTRUMENTS AIDS MAY  
233.32 BE PURCHASED FROM, THE LICENSED AUDIOLOGIST OR CERTIFIED DISPENSER  
233.33 OF YOUR CHOICE";

- 234.1 (ii) failed to give a copy of the audiogram, upon which the prescription or  
234.2 ~~recommendation~~ is based, to the consumer when the consumer requests a copy;
- 234.3 (iii) failed to provide the consumer rights brochure required by section 148.5197,  
234.4 subdivision 3;
- 234.5 (iv) failed to comply with restrictions on sales of prescription hearing instruments aids  
234.6 in sections 148.5197, subdivision 3, and 148.5198;
- 234.7 (v) failed to return a consumer's prescription hearing instrument aid used as a trade-in  
234.8 or for a discount in the price of a new prescription hearing instrument aid when requested  
234.9 by the consumer upon cancellation of the purchase agreement;
- 234.10 (vi) failed to follow Food and Drug Administration or Federal Trade Commission  
234.11 regulations relating to dispensing prescription hearing instruments aids;
- 234.12 (vii) failed to dispense a prescription hearing instrument aid in a competent manner or  
234.13 without appropriate training;
- 234.14 (viii) delegated prescription hearing instrument aid dispensing authority to a person not  
234.15 authorized to dispense a prescription hearing instrument aid under this chapter or chapter  
234.16 153A;
- 234.17 (ix) failed to comply with the requirements of an employer or supervisor of a hearing  
234.18 instrument aid dispenser trainee;
- 234.19 (x) violated a state or federal court order or judgment, including a conciliation court  
234.20 judgment, relating to the activities of the individual's prescription hearing instrument aid  
234.21 dispensing; or
- 234.22 (xi) failed to include on the audiogram the practitioner's printed name, credential type,  
234.23 credential number, signature, and date.
- 234.24 Sec. 142. Minnesota Statutes 2022, section 148.5196, subdivision 1, is amended to read:
- 234.25 Subdivision 1. **Membership.** The commissioner shall appoint 12 persons to a  
234.26 Speech-Language Pathologist and Audiologist Advisory Council. The 12 persons must  
234.27 include:
- 234.28 (1) three public members, as defined in section 214.02. Two of the public members shall  
234.29 be either persons receiving services of a speech-language pathologist or audiologist, or  
234.30 family members of or caregivers to such persons, and at least one of the public members  
234.31 shall be either a hearing instrument aid user or an advocate of one;

235.1 (2) three speech-language pathologists licensed under sections 148.511 to 148.5198,  
235.2 one of whom is currently and has been, for the five years immediately preceding the  
235.3 appointment, engaged in the practice of speech-language pathology in Minnesota and each  
235.4 of whom is employed in a different employment setting including, but not limited to, private  
235.5 practice, hospitals, rehabilitation settings, educational settings, and government agencies;

235.6 (3) one speech-language pathologist licensed under sections 148.511 to 148.5198, who  
235.7 is currently and has been, for the five years immediately preceding the appointment,  
235.8 employed by a Minnesota public school district or a Minnesota public school district  
235.9 consortium that is authorized by Minnesota Statutes and who is licensed in speech-language  
235.10 pathology by the Professional Educator Licensing and Standards Board;

235.11 (4) three audiologists licensed under sections 148.511 to 148.5198, two of whom are  
235.12 currently and have been, for the five years immediately preceding the appointment, engaged  
235.13 in the practice of audiology and the dispensing of prescription hearing instruments aids in  
235.14 Minnesota and each of whom is employed in a different employment setting including, but  
235.15 not limited to, private practice, hospitals, rehabilitation settings, educational settings, industry,  
235.16 and government agencies;

235.17 (5) one nonaudiologist hearing ~~instrument~~ aid dispenser recommended by a professional  
235.18 association representing hearing ~~instrument~~ aid dispensers; and

235.19 (6) one physician licensed under chapter 147 and certified by the American Board of  
235.20 Otolaryngology, Head and Neck Surgery.

235.21 Sec. 143. Minnesota Statutes 2022, section 148.5197, is amended to read:

235.22 **148.5197 HEARING AID DISPENSING.**

235.23 Subdivision 1. **Content of contracts.** Oral statements made by an audiologist or certified  
235.24 dispenser regarding the provision of warranties, refunds, and service on the prescription  
235.25 hearing aid or aids dispensed must be written on, and become part of, the contract of sale,  
235.26 specify the item or items covered, and indicate the person or business entity obligated to  
235.27 provide the warranty, refund, or service.

235.28 Subd. 2. **Required use of license number.** The audiologist's license number or certified  
235.29 dispenser's certificate number must appear on all contracts, bills of sale, and receipts used  
235.30 in the sale of prescription hearing aids.

235.31 Subd. 3. **Consumer rights information.** An audiologist or certified dispenser shall, at  
235.32 the time of the ~~recommendation~~ or prescription, give a consumer rights brochure, prepared  
235.33 by the commissioner and containing information about legal requirements pertaining to

236.1 dispensing of prescription hearing aids, to each potential consumer of a prescription hearing  
236.2 aid. The brochure must contain information about the consumer information center described  
236.3 in section 153A.18. A contract for a prescription hearing aid must note the receipt of the  
236.4 brochure by the consumer, along with the consumer's signature or initials.

236.5 Subd. 4. **Liability for contracts.** Owners of entities in the business of dispensing  
236.6 prescription hearing aids, employers of audiologists or persons who dispense prescription  
236.7 hearing aids, supervisors of trainees or audiology students, and hearing aid dispensers  
236.8 conducting the transaction at issue are liable for satisfying all terms of contracts, written or  
236.9 oral, made by their agents, employees, assignees, affiliates, or trainees, including terms  
236.10 relating to products, repairs, warranties, service, and refunds. The commissioner may enforce  
236.11 the terms of prescription hearing aid contracts against the principal, employer, supervisor,  
236.12 or dispenser who conducted the transaction and may impose any remedy provided for in  
236.13 this chapter.

236.14 Sec. 144. Minnesota Statutes 2022, section 148.5198, is amended to read:

236.15 **148.5198 RESTRICTION ON SALE OF PRESCRIPTION HEARING AIDS.**

236.16 Subdivision 1. **45-calendar-day guarantee and buyer right to cancel.** (a) An audiologist  
236.17 or certified dispenser dispensing a prescription hearing aid in this state must comply with  
236.18 paragraphs (b) and (c).

236.19 (b) The audiologist or certified dispenser must provide the buyer with a 45-calendar-day  
236.20 written money-back guarantee. The guarantee must permit the buyer to cancel the purchase  
236.21 for any reason within 45 calendar days after receiving the prescription hearing aid by giving  
236.22 or mailing written notice of cancellation to the audiologist or certified dispenser. If the buyer  
236.23 mails the notice of cancellation, the 45-calendar-day period is counted using the postmark  
236.24 date, to the date of receipt by the audiologist or certified dispenser. If the prescription hearing  
236.25 aid must be repaired, remade, or adjusted during the 45-calendar-day money-back guarantee  
236.26 period, the running of the 45-calendar-day period is suspended one day for each 24-hour  
236.27 period that the prescription hearing aid is not in the buyer's possession. A repaired, remade,  
236.28 or adjusted prescription hearing aid must be claimed by the buyer within three business  
236.29 days after notification of availability, after which time the running of the 45-calendar-day  
236.30 period resumes. The guarantee must entitle the buyer, upon cancellation, to receive a refund  
236.31 of payment within 30 days of return of the prescription hearing aid to the audiologist or  
236.32 certified dispenser. The audiologist or certified dispenser may retain as a cancellation fee  
236.33 no more than \$250 of the buyer's total purchase price of the prescription hearing aid.

237.1 (c) The audiologist or certified dispenser shall provide the buyer with a contract written  
237.2 in plain English, that contains uniform language and provisions that meet the requirements  
237.3 under the Plain Language Contract Act, sections 325G.29 to 325G.36. The contract must  
237.4 include, but is not limited to, the following: in immediate proximity to the space reserved  
237.5 for the signature of the buyer, or on the first page if there is no space reserved for the  
237.6 signature of the buyer, a clear and conspicuous disclosure of the following specific statement  
237.7 in all capital letters of no less than 12-point boldface type: "MINNESOTA STATE LAW  
237.8 GIVES THE BUYER THE RIGHT TO CANCEL THIS PURCHASE FOR ANY REASON  
237.9 AT ANY TIME PRIOR TO MIDNIGHT OF THE 45TH CALENDAR DAY AFTER  
237.10 RECEIPT OF THE PRESCRIPTION HEARING AID(S). THIS CANCELLATION MUST  
237.11 BE IN WRITING AND MUST BE GIVEN OR MAILED TO THE AUDIOLOGIST OR  
237.12 CERTIFIED DISPENSER. IF THE BUYER DECIDES TO RETURN THE PRESCRIPTION  
237.13 HEARING AID(S) WITHIN THIS 45-CALENDAR-DAY PERIOD, THE BUYER WILL  
237.14 RECEIVE A REFUND OF THE TOTAL PURCHASE PRICE OF THE AID(S) FROM  
237.15 WHICH THE AUDIOLOGIST OR CERTIFIED DISPENSER MAY RETAIN AS A  
237.16 CANCELLATION FEE NO MORE THAN \$250."

237.17 Subd. 2. **Itemized repair bill.** Any audiologist, certified dispenser, or company who  
237.18 agrees to repair a prescription hearing aid must provide the owner of the prescription hearing  
237.19 aid, or the owner's representative, with a bill that describes the repair and services rendered.  
237.20 The bill must also include the repairing audiologist's, certified dispenser's, or company's  
237.21 name, address, and telephone number.

237.22 This subdivision does not apply to an audiologist, certified dispenser, or company that  
237.23 repairs a prescription hearing aid pursuant to an express warranty covering the entire  
237.24 prescription hearing aid and the warranty covers the entire cost, both parts and labor, of the  
237.25 repair.

237.26 Subd. 3. **Repair warranty.** Any guarantee of prescription hearing aid repairs must be  
237.27 in writing and delivered to the owner of the prescription hearing aid, or the owner's  
237.28 representative, stating the repairing audiologist's, certified dispenser's, or company's name,  
237.29 address, telephone number, length of guarantee, model, and serial number of the prescription  
237.30 hearing aid and all other terms and conditions of the guarantee.

237.31 Subd. 4. **Misdemeanor.** A person found to have violated this section is guilty of a  
237.32 misdemeanor.

238.1 Subd. 5. **Additional.** In addition to the penalty provided in subdivision 4, a person found  
238.2 to have violated this section is subject to the penalties and remedies provided in section  
238.3 325F.69, subdivision 1.

238.4 Subd. 6. **Estimates.** Upon the request of the owner of a prescription hearing aid or the  
238.5 owner's representative for a written estimate and prior to the commencement of repairs, a  
238.6 repairing audiologist, certified dispenser, or company shall provide the customer with a  
238.7 written estimate of the price of repairs. If a repairing audiologist, certified dispenser, or  
238.8 company provides a written estimate of the price of repairs, it must not charge more than  
238.9 the total price stated in the estimate for the repairs. If the repairing audiologist, certified  
238.10 dispenser, or company after commencing repairs determines that additional work is necessary  
238.11 to accomplish repairs that are the subject of a written estimate and if the repairing audiologist,  
238.12 certified dispenser, or company did not unreasonably fail to disclose the possible need for  
238.13 the additional work when the estimate was made, the repairing audiologist, certified  
238.14 dispenser, or company may charge more than the estimate for the repairs if the repairing  
238.15 audiologist, certified dispenser, or company immediately provides the owner or owner's  
238.16 representative a revised written estimate pursuant to this section and receives authorization  
238.17 to continue with the repairs. If continuation of the repairs is not authorized, the repairing  
238.18 audiologist, certified dispenser, or company shall return the prescription hearing aid as close  
238.19 as possible to its former condition and shall release the prescription hearing aid to the owner  
238.20 or owner's representative upon payment of charges for repairs actually performed and not  
238.21 in excess of the original estimate.

238.22 Sec. 145. Minnesota Statutes 2022, section 151.37, subdivision 12, is amended to read:

238.23 Subd. 12. **Administration of opiate antagonists for drug overdose.** (a) A licensed  
238.24 physician, a licensed advanced practice registered nurse authorized to prescribe drugs  
238.25 pursuant to section 148.235, or a licensed physician assistant may authorize the following  
238.26 individuals to administer opiate antagonists, as defined in section 604A.04, subdivision 1:

- 238.27 (1) an emergency medical responder registered pursuant to section 144E.27;
- 238.28 (2) a peace officer as defined in section 626.84, subdivision 1, paragraphs (c) and (d);
- 238.29 (3) correctional employees of a state or local political subdivision;
- 238.30 (4) staff of community-based health disease prevention or social service programs;
- 238.31 (5) a volunteer firefighter; and

239.1 (6) a ~~licensed school nurse or certified public health nurse~~ any other personnel employed  
239.2 by, or under contract with, a ~~school board under section 121A.21~~ charter, public, or private  
239.3 school.

239.4 (b) For the purposes of this subdivision, opiate antagonists may be administered by one  
239.5 of these individuals only if:

239.6 (1) the licensed physician, licensed physician assistant, or licensed advanced practice  
239.7 registered nurse has issued a standing order to, or entered into a protocol with, the individual;  
239.8 and

239.9 (2) the individual has training in the recognition of signs of opiate overdose and the use  
239.10 of opiate antagonists as part of the emergency response to opiate overdose.

239.11 (c) Nothing in this section prohibits the possession and administration of naloxone  
239.12 pursuant to section 604A.04.

239.13 (d) Notwithstanding section 148.235, subdivisions 8 and 9, a licensed practical nurse is  
239.14 authorized to possess and administer according to this subdivision an opiate antagonist in  
239.15 a school setting.

239.16 Sec. 146. Minnesota Statutes 2022, section 153A.13, subdivision 3, is amended to read:

239.17 Subd. 3. **Hearing instrument aid.** "Hearing instrument aid" means an instrument, ~~or~~  
239.18 ~~any of its parts, worn in the ear canal and designed to or represented as being able to aid or~~  
239.19 ~~enhance human hearing. "Hearing instrument" includes the instrument's parts, attachments,~~  
239.20 ~~or accessories, including, but not limited to, ear molds and behind the ear (BTE) devices~~  
239.21 ~~with or without an ear mold. Batteries and cords are not parts, attachments, or accessories~~  
239.22 ~~of a hearing instrument. Surgically implanted hearing instruments, and assistive listening~~  
239.23 ~~devices not worn within the ear canal, are not hearing instruments. as defined in section~~  
239.24 148.512, subdivision 10a.

239.25 Sec. 147. Minnesota Statutes 2022, section 153A.13, subdivision 4, is amended to read:

239.26 Subd. 4. **Hearing instrument aid dispensing.** "Hearing instrument aid dispensing"  
239.27 ~~means making ear mold impressions, prescribing, or recommending a hearing instrument,~~  
239.28 ~~assisting the consumer in instrument selection, selling hearing instruments at retail, or testing~~  
239.29 ~~human hearing in connection with these activities regardless of whether the person conducting~~  
239.30 ~~these activities has a monetary interest in the sale of hearing instruments to the consumer.~~  
239.31 has the meaning given in section 148.512, subdivision 10b.

240.1 Sec. 148. Minnesota Statutes 2022, section 153A.13, subdivision 5, is amended to read:

240.2 Subd. 5. **Dispenser of hearing ~~instruments~~ aids.** "Dispenser of hearing ~~instruments~~  
240.3 aids" means a natural person who engages in prescription hearing ~~instrument~~ aid dispensing,  
240.4 whether or not certified by the commissioner of health or licensed by an existing  
240.5 health-related board, except that a person described as follows is not a dispenser of hearing  
240.6 ~~instruments~~ aids:

240.7 (1) a student participating in supervised field work that is necessary to meet requirements  
240.8 of an accredited educational program if the student is designated by a title which clearly  
240.9 indicates the student's status as a student trainee; or

240.10 (2) a person who helps a dispenser of hearing ~~instruments~~ aids in an administrative or  
240.11 clerical manner and does not engage in prescription hearing ~~instrument~~ aid dispensing.

240.12 A person who offers to dispense a prescription hearing ~~instrument~~ aid, or a person who  
240.13 advertises, holds out to the public, or otherwise represents that the person is authorized to  
240.14 dispense prescription hearing ~~instruments~~ aids, must be certified by the commissioner except  
240.15 when the person is an audiologist as defined in section 148.512.

240.16 Sec. 149. Minnesota Statutes 2022, section 153A.13, subdivision 6, is amended to read:

240.17 Subd. 6. **Advisory council.** "Advisory council" means the Minnesota Hearing ~~Instrument~~  
240.18 Aid Dispenser Advisory Council, or a committee of ~~it~~ the council, established under section  
240.19 153A.20.

240.20 Sec. 150. Minnesota Statutes 2022, section 153A.13, subdivision 7, is amended to read:

240.21 Subd. 7. **ANSI.** "ANSI" means ~~ANSI S3.6-1989~~, American National Standard  
240.22 Specification for Audiometers ~~from the American National Standards Institute. This~~  
240.23 ~~document is available through the Minitex interlibrary loan system~~ as defined in the United  
240.24 States Food and Drug Administration, Code of Federal Regulations, title 21, section  
240.25 874.1050.

240.26 Sec. 151. Minnesota Statutes 2022, section 153A.13, subdivision 9, is amended to read:

240.27 Subd. 9. **Supervision.** "Supervision" means monitoring activities of, and accepting  
240.28 responsibility for, the prescription hearing ~~instrument~~ aid dispensing activities of a trainee.

241.1 Sec. 152. Minnesota Statutes 2022, section 153A.13, subdivision 10, is amended to read:

241.2 Subd. 10. **Direct supervision or directly supervised.** "Direct supervision" or "directly  
241.3 supervised" means the on-site and contemporaneous location of a supervisor and trainee,  
241.4 when the supervisor observes the trainee engaging in prescription hearing instrument aid  
241.5 dispensing with a consumer.

241.6 Sec. 153. Minnesota Statutes 2022, section 153A.13, subdivision 11, is amended to read:

241.7 Subd. 11. **Indirect supervision or indirectly supervised.** "Indirect supervision" or  
241.8 "indirectly supervised" means the remote and independent performance of prescription  
241.9 hearing instrument aid dispensing by a trainee when authorized under section 153A.14,  
241.10 subdivision 4a, paragraph (b).

241.11 Sec. 154. Minnesota Statutes 2022, section 153A.13, is amended by adding a subdivision  
241.12 to read:

241.13 Subd. 12. **Over-the-counter hearing aid or OTC hearing aid.** "Over-the-counter  
241.14 hearing aid" or "OTC hearing aid" has the meaning given in section 148.512, subdivision  
241.15 10c.

241.16 Sec. 155. Minnesota Statutes 2022, section 153A.13, is amended by adding a subdivision  
241.17 to read:

241.18 Subd. 13. **Prescription hearing aid.** "Prescription hearing aid" has the meaning given  
241.19 in section 148.512, subdivision 13a.

241.20 Sec. 156. Minnesota Statutes 2022, section 153A.14, subdivision 1, is amended to read:

241.21 Subdivision 1. **Application for certificate.** An applicant must:

241.22 (1) be 21 years of age or older;

241.23 (2) apply to the commissioner for a certificate to dispense prescription hearing instruments  
241.24 aids on application forms provided by the commissioner;

241.25 (3) at a minimum, provide the applicant's name, Social Security number, business address  
241.26 and phone number, employer, and information about the applicant's education, training,  
241.27 and experience in testing human hearing and fitting prescription hearing instruments aids;

241.28 (4) include with the application a statement that the statements in the application are  
241.29 true and correct to the best of the applicant's knowledge and belief;

242.1 (5) include with the application a written and signed authorization that authorizes the  
242.2 commissioner to make inquiries to appropriate regulatory agencies in this or any other state  
242.3 where the applicant has sold prescription hearing instruments aids;

242.4 (6) submit certification to the commissioner that the applicant's audiometric equipment  
242.5 has been calibrated to meet current ANSI standards within 12 months of the date of the  
242.6 application;

242.7 (7) submit evidence of continuing education credits, if required;

242.8 (8) submit all fees as required under section 153A.17; and

242.9 (9) consent to a fingerprint-based criminal history records check required under section  
242.10 144.0572, pay all required fees, and cooperate with all requests for information. An applicant  
242.11 must complete a new criminal background check if more than one year has elapsed since  
242.12 the applicant last applied for a license.

242.13 Sec. 157. Minnesota Statutes 2022, section 153A.14, subdivision 2, is amended to read:

242.14 Subd. 2. **Issuance of certificate.** (a) The commissioner shall issue a certificate to each  
242.15 dispenser of hearing instruments aids who applies under subdivision 1 if the commissioner  
242.16 determines that the applicant is in compliance with this chapter, has passed an examination  
242.17 administered by the commissioner, has met the continuing education requirements, if  
242.18 required, and has paid the fee set by the commissioner. The commissioner may reject or  
242.19 deny an application for a certificate if there is evidence of a violation or failure to comply  
242.20 with this chapter.

242.21 (b) The commissioner shall not issue a certificate to an applicant who refuses to consent  
242.22 to a criminal history background check as required by section 144.0572 within 90 days after  
242.23 submission of an application or fails to submit fingerprints to the Department of Human  
242.24 Services. Any fees paid by the applicant to the Department of Health shall be forfeited if  
242.25 the applicant refuses to consent to the background study.

242.26 Sec. 158. Minnesota Statutes 2022, section 153A.14, subdivision 2h, is amended to read:

242.27 Subd. 2h. **Certification by examination.** An applicant must achieve a passing score,  
242.28 as determined by the commissioner, on an examination according to paragraphs (a) to (c).

242.29 (a) The examination must include, but is not limited to:

242.30 (1) A written examination approved by the commissioner covering the following areas  
242.31 as they pertain to prescription hearing instrument aid selling:

- 243.1 (i) basic physics of sound;
- 243.2 (ii) the anatomy and physiology of the ear;
- 243.3 (iii) the function of prescription hearing instruments aids; and
- 243.4 (iv) the principles of prescription hearing instrument aid selection.
- 243.5 (2) Practical tests of proficiency in the following techniques as they pertain to prescription
- 243.6 hearing instrument aid selling:
- 243.7 (i) pure tone audiometry, including air conduction testing and bone conduction testing;
- 243.8 (ii) live voice or recorded voice speech audiometry including speech recognition
- 243.9 (discrimination) testing, most comfortable loudness level, and uncomfortable loudness
- 243.10 measurements of tolerance thresholds;
- 243.11 (iii) masking when indicated;
- 243.12 (iv) recording and evaluation of audiograms and speech audiometry to determine proper
- 243.13 selection and fitting of a prescription hearing instrument aid;
- 243.14 (v) taking ear mold impressions;
- 243.15 (vi) using an otoscope for the visual observation of the entire ear canal; and
- 243.16 (vii) state and federal laws, rules, and regulations.
- 243.17 (b) The practical examination shall be administered by the commissioner at least twice
- 243.18 a year.
- 243.19 (c) An applicant must achieve a passing score on all portions of the examination within
- 243.20 a two-year period. An applicant who does not achieve a passing score on all portions of the
- 243.21 examination within a two-year period must retake the entire examination and achieve a
- 243.22 passing score on each portion of the examination. An applicant who does not apply for
- 243.23 certification within one year of successful completion of the examination must retake the
- 243.24 examination and achieve a passing score on each portion of the examination. An applicant
- 243.25 may not take any part of the practical examination more than three times in a two-year
- 243.26 period.
- 243.27 Sec. 159. Minnesota Statutes 2022, section 153A.14, subdivision 2i, is amended to read:
- 243.28 Subd. 2i. **Continuing education requirement.** On forms provided by the commissioner,
- 243.29 each certified dispenser must submit with the application for renewal of certification evidence
- 243.30 of completion of ten course hours of continuing education earned within the 12-month
- 243.31 period of November 1 to October 31, between the effective and expiration dates of

244.1 certification. Continuing education courses must be directly related to prescription hearing  
244.2 ~~instrument~~ aid dispensing and approved by the International Hearing Society, the American  
244.3 Speech-Language-Hearing Association, or the American Academy of Audiology. Evidence  
244.4 of completion of the ten course hours of continuing education must be submitted by  
244.5 December 1 of each year. This requirement does not apply to dispensers certified for less  
244.6 than one year.

244.7 Sec. 160. Minnesota Statutes 2022, section 153A.14, subdivision 2j, is amended to read:

244.8 Subd. 2j. **Required use of certification number.** The certification holder must use the  
244.9 certification number on all contracts, bills of sale, and receipts used in the sale of prescription  
244.10 hearing ~~instruments~~ aids.

244.11 Sec. 161. Minnesota Statutes 2022, section 153A.14, subdivision 4, is amended to read:

244.12 Subd. 4. **Dispensing of prescription hearing ~~instruments~~ aids without**  
244.13 **certificate.** Except as provided in subdivisions 4a and 4c, and in sections 148.512 to  
244.14 148.5198, it is unlawful for any person not holding a valid certificate to dispense a  
244.15 prescription hearing ~~instrument~~ aid as defined in section 153A.13, subdivision 3. A person  
244.16 who dispenses a prescription hearing ~~instrument~~ aid without the certificate required by this  
244.17 section is guilty of a gross misdemeanor.

244.18 Sec. 162. Minnesota Statutes 2022, section 153A.14, subdivision 4a, is amended to read:

244.19 Subd. 4a. **Trainees.** (a) A person who is not certified under this section may dispense  
244.20 prescription hearing ~~instruments~~ aids as a trainee for a period not to exceed 12 months if  
244.21 the person:

244.22 (1) submits an application on forms provided by the commissioner;

244.23 (2) is under the supervision of a certified dispenser meeting the requirements of this  
244.24 subdivision;

244.25 (3) meets all requirements for certification except passage of the examination required  
244.26 by this section; and

244.27 (4) uses the title "dispenser trainee" in contacts with the patients, clients, or consumers.

244.28 (b) A certified hearing ~~instrument~~ aid dispenser may not supervise more than two trainees  
244.29 at the same time and may not directly supervise more than one trainee at a time. The certified  
244.30 dispenser is responsible for all actions or omissions of a trainee in connection with the  
244.31 dispensing of prescription hearing ~~instruments~~ aids. A certified dispenser may not supervise

245.1 a trainee if there are any commissioner, court, or other orders, currently in effect or issued  
245.2 within the last five years, that were issued with respect to an action or omission of a certified  
245.3 dispenser or a trainee under the certified dispenser's supervision.

245.4 Until taking and passing the practical examination testing the techniques described in  
245.5 subdivision 2h, paragraph (a), clause (2), trainees must be directly supervised in all areas  
245.6 described in subdivision 4b, and the activities tested by the practical examination. Thereafter,  
245.7 trainees may dispense prescription hearing instruments aids under indirect supervision until  
245.8 expiration of the trainee period. Under indirect supervision, the trainee must complete two  
245.9 monitored activities a week. Monitored activities may be executed by correspondence,  
245.10 telephone, or other telephonic devices, and include, but are not limited to, evaluation of  
245.11 audiograms, written reports, and contracts. The time spent in supervision must be recorded  
245.12 and the record retained by the supervisor.

245.13 Sec. 163. Minnesota Statutes 2022, section 153A.14, subdivision 4b, is amended to read:

245.14 Subd. 4b. **Prescription hearing testing protocol.** A dispenser when conducting a hearing  
245.15 test for the purpose of prescription hearing instrument aid dispensing must:

245.16 (1) comply with the United States Food and Drug Administration warning regarding  
245.17 potential medical conditions required by Code of Federal Regulations, title 21, section  
245.18 ~~801.420~~ 801.422;

245.19 (2) complete a case history of the client's hearing;

245.20 (3) inspect the client's ears with an otoscope; and

245.21 (4) conduct the following tests on both ears of the client and document the results, and  
245.22 if for any reason one of the following tests cannot be performed pursuant to the United  
245.23 States Food and Drug Administration guidelines, an audiologist shall evaluate the hearing  
245.24 and the need for a prescription hearing instrument aid:

245.25 (i) air conduction at 250, 500, 1,000, 2,000, 4,000, and 8,000 Hertz. When a difference  
245.26 of 20 dB or more occurs between adjacent octave frequencies the interoctave frequency  
245.27 must be tested;

245.28 (ii) bone conduction at 500, 1,000, 2,000, and 4,000 Hertz for any frequency where the  
245.29 air conduction threshold is greater than 15 dB HL;

245.30 (iii) monaural word recognition (discrimination), with a minimum of 25 words presented  
245.31 for each ear; and

246.1 (iv) loudness discomfort level, monaural, for setting a prescription hearing instrument's  
246.2 aid's maximum power output; and

246.3 (5) include masking in all tests whenever necessary to ensure accurate results.

246.4 Sec. 164. Minnesota Statutes 2022, section 153A.14, subdivision 4c, is amended to read:

246.5 Subd. 4c. **Reciprocity.** (a) A person who has dispensed prescription hearing instruments  
246.6 aids in another jurisdiction may dispense prescription hearing instruments aids as a trainee  
246.7 under indirect supervision if the person:

246.8 (1) satisfies the provisions of subdivision 4a, paragraph (a);

246.9 (2) submits a signed and dated affidavit stating that the applicant is not the subject of a  
246.10 disciplinary action or past disciplinary action in this or another jurisdiction and is not  
246.11 disqualified on the basis of section 153A.15, subdivision 1; and

246.12 (3) provides a copy of a current credential as a hearing ~~instrument~~ aid dispenser held in  
246.13 the District of Columbia or a state or territory of the United States.

246.14 (b) A person becoming a trainee under this subdivision who fails to take and pass the  
246.15 practical examination described in subdivision 2h, paragraph (a), clause (2), when next  
246.16 offered must cease dispensing prescription hearing instruments aids unless under direct  
246.17 supervision.

246.18 Sec. 165. Minnesota Statutes 2022, section 153A.14, subdivision 4e, is amended to read:

246.19 Subd. 4e. **Prescription hearing aids; enforcement.** Costs incurred by the Minnesota  
246.20 Department of Health for conducting investigations of unlicensed prescription hearing aid  
246.21 ~~dispensers~~ dispensing shall be apportioned between all licensed or credentialed professions  
246.22 that dispense prescription hearing aids.

246.23 Sec. 166. Minnesota Statutes 2022, section 153A.14, subdivision 6, is amended to read:

246.24 Subd. 6. **Prescription hearing ~~instruments~~ aids to comply with federal and state**  
246.25 **requirements.** The commissioner shall ensure that prescription hearing instruments aids  
246.26 are dispensed in compliance with state requirements and the requirements of the United  
246.27 States Food and Drug Administration. Failure to comply with state or federal regulations  
246.28 may be grounds for enforcement actions under section 153A.15, subdivision 2.

247.1 Sec. 167. Minnesota Statutes 2022, section 153A.14, subdivision 9, is amended to read:

247.2 Subd. 9. **Consumer rights.** A hearing ~~instrument~~ aid dispenser shall comply with the  
247.3 requirements of sections 148.5195, subdivision 3, clause (20); 148.5197; and 148.5198.

247.4 Sec. 168. Minnesota Statutes 2022, section 153A.14, subdivision 11, is amended to read:

247.5 Subd. 11. **Requirement to maintain current information.** A dispenser must notify the  
247.6 commissioner in writing within 30 days of the occurrence of any of the following:

247.7 (1) a change of name, address, home or business telephone number, or business name;

247.8 (2) the occurrence of conduct prohibited by section 153A.15;

247.9 (3) a settlement, conciliation court judgment, or award based on negligence, intentional  
247.10 acts, or contractual violations committed in the dispensing of prescription hearing instruments  
247.11 aids by the dispenser; and

247.12 (4) the cessation of prescription hearing instrument aid dispensing activities as an  
247.13 individual or a business.

247.14 Sec. 169. Minnesota Statutes 2022, section 153A.14, is amended by adding a subdivision  
247.15 to read:

247.16 Subd. 12. **Over-the-counter hearing aids.** Nothing in this chapter shall preclude certified  
247.17 hearing aid dispensers from dispensing or selling over-the-counter hearing aids.

247.18 Sec. 170. Minnesota Statutes 2022, section 153A.15, subdivision 1, is amended to read:

247.19 Subdivision 1. **Prohibited acts.** The commissioner may take enforcement action as  
247.20 provided under subdivision 2 against a dispenser of prescription hearing instruments aids  
247.21 for the following acts and conduct:

247.22 (1) dispensing a prescription hearing instrument aid to a minor person 18 years or younger  
247.23 unless evaluated by an audiologist for hearing evaluation and prescription hearing aid  
247.24 evaluation;

247.25 (2) being disciplined through a revocation, suspension, restriction, or limitation by  
247.26 another state for conduct subject to action under this chapter;

247.27 (3) presenting advertising that is false or misleading;

247.28 (4) providing the commissioner with false or misleading statements of credentials,  
247.29 training, or experience;

- 248.1 (5) engaging in conduct likely to deceive, defraud, or harm the public; or demonstrating  
248.2 a willful or careless disregard for the health, welfare, or safety of a consumer;
- 248.3 (6) splitting fees or promising to pay a portion of a fee to any other professional other  
248.4 than a fee for services rendered by the other professional to the client;
- 248.5 (7) engaging in abusive or fraudulent billing practices, including violations of federal  
248.6 Medicare and Medicaid laws, Food and Drug Administration regulations, or state medical  
248.7 assistance laws;
- 248.8 (8) obtaining money, property, or services from a consumer through the use of undue  
248.9 influence, high pressure sales tactics, harassment, duress, deception, or fraud;
- 248.10 (9) performing the services of a certified hearing ~~instrument~~ aid dispenser in an  
248.11 incompetent or negligent manner;
- 248.12 (10) failing to comply with the requirements of this chapter as an employer, supervisor,  
248.13 or trainee;
- 248.14 (11) failing to provide information in a timely manner in response to a request by the  
248.15 commissioner, commissioner's designee, or the advisory council;
- 248.16 (12) being convicted within the past five years of violating any laws of the United States,  
248.17 or any state or territory of the United States, and the violation is a felony, gross misdemeanor,  
248.18 or misdemeanor, an essential element of which relates to prescription hearing ~~instrument~~  
248.19 aid dispensing, except as provided in chapter 364;
- 248.20 (13) failing to cooperate with the commissioner, the commissioner's designee, or the  
248.21 advisory council in any investigation;
- 248.22 (14) failing to perform prescription hearing ~~instrument~~ aid dispensing with reasonable  
248.23 judgment, skill, or safety due to the use of alcohol or drugs, or other physical or mental  
248.24 impairment;
- 248.25 (15) failing to fully disclose actions taken against the applicant or the applicant's legal  
248.26 authorization to dispense prescription hearing ~~instruments~~ aids in this or another state;
- 248.27 (16) violating a state or federal court order or judgment, including a conciliation court  
248.28 judgment, relating to the activities of the applicant in prescription hearing ~~instrument~~ aid  
248.29 dispensing;
- 248.30 (17) having been or being disciplined by the commissioner of the Department of Health,  
248.31 or other authority, in this or another jurisdiction, if any of the grounds for the discipline are  
248.32 the same or substantially equivalent to those in sections 153A.13 to 153A.18;

249.1 (18) misrepresenting the purpose of hearing tests, or in any way communicating that the  
249.2 hearing test or hearing test protocol required by section 153A.14, subdivision 4b, is a medical  
249.3 evaluation, a diagnostic hearing evaluation conducted by an audiologist, or is other than a  
249.4 test to select a prescription hearing instrument aid, except that the hearing instrument aid  
249.5 dispenser can determine the need for or recommend the consumer obtain a medical evaluation  
249.6 consistent with requirements of the United States Food and Drug Administration;

249.7 (19) violating any of the provisions of sections 148.5195, subdivision 3, clause (20);  
249.8 148.5197; 148.5198; and 153A.13 to 153A.18; and

249.9 (20) aiding or abetting another person in violating any of the provisions of sections  
249.10 148.5195, subdivision 3, clause (20); 148.5197; 148.5198; and 153A.13 to 153A.18.

249.11 Sec. 171. Minnesota Statutes 2022, section 153A.15, subdivision 2, is amended to read:

249.12 Subd. 2. **Enforcement actions.** When the commissioner finds that a dispenser of  
249.13 prescription hearing instruments aids has violated one or more provisions of this chapter,  
249.14 the commissioner may do one or more of the following:

249.15 (1) deny or reject the application for a certificate;

249.16 (2) revoke the certificate;

249.17 (3) suspend the certificate;

249.18 (4) impose, for each violation, a civil penalty that deprives the dispenser of any economic  
249.19 advantage gained by the violation and that reimburses the Department of Health for costs  
249.20 of the investigation and proceeding resulting in disciplinary action, including the amount  
249.21 paid for services of the Office of Administrative Hearings, the amount paid for services of  
249.22 the Office of the Attorney General, attorney fees, court reporters, witnesses, reproduction  
249.23 of records, advisory council members' per diem compensation, department staff time, and  
249.24 expenses incurred by advisory council members and department staff;

249.25 (5) censure or reprimand the dispenser;

249.26 (6) revoke or suspend the right to supervise trainees;

249.27 (7) revoke or suspend the right to be a trainee;

249.28 (8) impose a civil penalty not to exceed \$10,000 for each separate violation; or

249.29 (9) any other action reasonably justified by the individual case.

250.1 Sec. 172. Minnesota Statutes 2022, section 153A.15, subdivision 4, is amended to read:

250.2 Subd. 4. **Penalties.** Except as provided in section 153A.14, subdivision 4, a person  
250.3 violating this chapter is guilty of a misdemeanor. The commissioner may impose an automatic  
250.4 civil penalty equal to one-fourth the renewal fee on each hearing ~~instrument seller~~ aid  
250.5 dispenser who fails to renew the certificate required in section 153A.14 by the renewal  
250.6 deadline.

250.7 Sec. 173. Minnesota Statutes 2022, section 153A.17, is amended to read:

250.8 **153A.17 EXPENSES; FEES.**

250.9 (a) The expenses for administering the certification requirements, including the complaint  
250.10 handling system for hearing aid dispensers in sections 153A.14 and 153A.15, and the  
250.11 Consumer Information Center under section 153A.18, must be paid from initial application  
250.12 and examination fees, renewal fees, penalties, and fines. The commissioner shall only use  
250.13 fees collected under this section for the purposes of administering this chapter. The legislature  
250.14 must not transfer money generated by these fees from the state government special revenue  
250.15 fund to the general fund. ~~Surcharges collected by the commissioner of health under section~~  
250.16 ~~16E.22 are not subject to this paragraph.~~

250.17 (b) The fees are as follows:

250.18 (1) the initial certification application fee is \$772.50;

250.19 (2) the annual renewal certification application fee is \$750;

250.20 (3) the initial examination fee for the practical portion is \$1,200, and \$600 for each time  
250.21 it is taken, thereafter; for individuals meeting the requirements of section 148.515, subdivision  
250.22 2, the fee for the practical portion of the prescription hearing instrument aid dispensing  
250.23 examination is \$600 each time it is taken;

250.24 (4) the trainee application fee is \$230;

250.25 (5) the penalty fee for late submission of a renewal application is \$260; and

250.26 (6) the fee for verification of certification to other jurisdictions or entities is \$25.

250.27 (c) The commissioner may prorate the certification fee for new applicants based on the  
250.28 number of quarters remaining in the annual certification period.

250.29 (d) All fees are nonrefundable. All fees, penalties, and fines received must be deposited  
250.30 in the state government special revenue fund.

251.1 (e) Hearing instrument dispensers who were certified before January 1, 2018, shall pay  
251.2 a onetime surcharge of \$22.50 to renew their certification when it expires after October 31,  
251.3 2020. The surcharge shall cover the commissioner's costs associated with criminal  
251.4 background checks.

251.5 Sec. 174. Minnesota Statutes 2022, section 153A.175, is amended to read:

251.6 **153A.175 PENALTY FEES.**

251.7 (a) The penalty fee for holding oneself out as a hearing ~~instrument~~ aid dispenser without  
251.8 a current certificate after the credential has expired and before it is renewed is one-half the  
251.9 amount of the certificate renewal fee for any part of the first day, plus one-half the certificate  
251.10 renewal fee for any part of any subsequent days up to 30 days.

251.11 (b) The penalty fee for applicants who hold themselves out as hearing ~~instrument~~ aid  
251.12 dispensers after expiration of the trainee period and before being issued a certificate is  
251.13 one-half the amount of the certificate application fee for any part of the first day, plus  
251.14 one-half the certificate application fee for any part of any subsequent days up to 30 days.  
251.15 This paragraph does not apply to applicants not qualifying for a certificate who hold  
251.16 themselves out as hearing ~~instrument~~ aid dispensers.

251.17 (c) The penalty fee for practicing prescription hearing ~~instrument~~ aid dispensing and  
251.18 failing to submit a continuing education report by the due date with the correct number or  
251.19 type of hours in the correct time period is \$200 plus \$200 for each missing clock hour.  
251.20 "Missing" means not obtained between the effective and expiration dates of the certificate,  
251.21 the one-month period following the certificate expiration date, or the 30 days following  
251.22 notice of a penalty fee for failing to report all continuing education hours. The certificate  
251.23 holder must obtain the missing number of continuing education hours by the next reporting  
251.24 due date.

251.25 (d) Civil penalties and discipline incurred by certificate holders prior to August 1, 2005,  
251.26 for conduct described in paragraph (a), (b), or (c) shall be recorded as nondisciplinary penalty  
251.27 fees. Payment of a penalty fee does not preclude any disciplinary action reasonably justified  
251.28 by the individual case.

251.29 Sec. 175. Minnesota Statutes 2022, section 153A.18, is amended to read:

251.30 **153A.18 CONSUMER INFORMATION CENTER.**

251.31 The commissioner shall establish a Consumer Information Center to assist actual and  
251.32 potential purchasers of prescription hearing aids by providing them with information

252.1 regarding prescription hearing instrument aid sales. The Consumer Information Center shall  
252.2 disseminate information about consumers' legal rights related to prescription hearing  
252.3 instrument aid sales, provide information relating to complaints about dispensers of  
252.4 prescription hearing instruments aids, and provide information about outreach and advocacy  
252.5 services for consumers of prescription hearing instruments aids. In establishing the center  
252.6 and developing the information, the commissioner shall consult with representatives of  
252.7 hearing instrument aid dispensers, audiologists, physicians, and consumers.

252.8 Sec. 176. Minnesota Statutes 2022, section 153A.20, is amended to read:

252.9 **153A.20 HEARING INSTRUMENT AID DISPENSER ADVISORY COUNCIL.**

252.10 Subdivision 1. **Membership.** (a) The commissioner shall appoint seven persons to a  
252.11 Hearing Instrument Aid Dispenser Advisory Council.

252.12 (b) The seven persons must include:

252.13 (1) three public members, as defined in section 214.02. At least one of the public members  
252.14 shall be a prescription hearing instrument aid user and one of the public members shall be  
252.15 either a prescription hearing instrument aid user or an advocate of one;

252.16 (2) three hearing instrument aid dispensers certified under sections 153A.14 to 153A.20,  
252.17 each of whom is currently, and has been for the five years immediately preceding their  
252.18 appointment, engaged in prescription hearing instrument aid dispensing in Minnesota and  
252.19 who represent the occupation of prescription hearing instrument aid dispensing and who  
252.20 are not audiologists; and

252.21 (3) one audiologist licensed as an audiologist under chapter 148 who dispenses  
252.22 prescription hearing instruments aids, recommended by a professional association  
252.23 representing audiologists and speech-language pathologists.

252.24 (c) The factors the commissioner may consider when appointing advisory council  
252.25 members include, but are not limited to, professional affiliation, geographical location, and  
252.26 type of practice.

252.27 (d) No two members of the advisory council shall be employees of, or have binding  
252.28 contracts requiring sales exclusively for, the same prescription hearing instrument aid  
252.29 manufacturer or the same employer.

252.30 Subd. 2. **Organization.** The advisory council shall be organized and administered  
252.31 according to section 15.059. The council may form committees to carry out its duties.

252.32 Subd. 3. **Duties.** At the commissioner's request, the advisory council shall:

253.1 (1) advise the commissioner regarding hearing ~~instrument~~ aid dispenser certification  
253.2 standards;

253.3 (2) provide for distribution of information regarding hearing ~~instrument~~ aid dispenser  
253.4 certification standards;

253.5 (3) review investigation summaries of competency violations and make recommendations  
253.6 to the commissioner as to whether the allegations of incompetency are substantiated; and

253.7 (4) perform other duties as directed by the commissioner.

253.8 Sec. 177. Minnesota Statutes 2022, section 256B.434, subdivision 4f, is amended to read:

253.9 Subd. 4f. **Construction project rate adjustments effective October 1, 2006.** (a)

253.10 Effective October 1, 2006, facilities reimbursed under this section may receive a property  
253.11 rate adjustment for construction projects exceeding the threshold in section 256B.431,  
253.12 subdivision 16, and below the threshold in section 144A.071, subdivision 2, ~~clause (a)~~  
253.13 paragraph (c), clause (1). For these projects, capital assets purchased shall be counted as  
253.14 construction project costs for a rate adjustment request made by a facility if they are: (1)  
253.15 purchased within 24 months of the completion of the construction project; (2) purchased  
253.16 after the completion date of any prior construction project; and (3) are not purchased prior  
253.17 to July 14, 2005. Except as otherwise provided in this subdivision, the definitions, rate  
253.18 calculation methods, and principles in sections 144A.071 and 256B.431 and Minnesota  
253.19 Rules, parts 9549.0010 to 9549.0080, shall be used to calculate rate adjustments for allowable  
253.20 construction projects under this subdivision and section 144A.073. Facilities completing  
253.21 construction projects between October 1, 2005, and October 1, 2006, are eligible to have a  
253.22 property rate adjustment effective October 1, 2006. Facilities completing projects after  
253.23 October 1, 2006, are eligible for a property rate adjustment effective on the first day of the  
253.24 month following the completion date. Facilities completing projects after January 1, 2018,  
253.25 are eligible for a property rate adjustment effective on the first day of the month of January  
253.26 or July, whichever occurs immediately following the completion date.

253.27 (b) Notwithstanding subdivision 18, as of July 14, 2005, facilities with rates set under  
253.28 section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, that commenced a  
253.29 construction project on or after October 1, 2004, and do not have a contract under subdivision  
253.30 3 by September 30, 2006, are eligible to request a rate adjustment under section 256B.431,  
253.31 subdivision 10, through September 30, 2006. If the request results in the commissioner  
253.32 determining a rate adjustment is allowable, the rate adjustment is effective on the first of  
253.33 the month following project completion. These facilities shall be allowed to accumulate  
253.34 construction project costs for the period October 1, 2004, to September 30, 2006.

254.1 (c) Facilities shall be allowed construction project rate adjustments no sooner than 12  
254.2 months after completing a previous construction project. Facilities must request the rate  
254.3 adjustment according to section 256B.431, subdivision 10.

254.4 (d) Capacity days shall be computed according to Minnesota Rules, part 9549.0060,  
254.5 subpart 11. For rate calculations under this section, the number of licensed beds in the  
254.6 nursing facility shall be the number existing after the construction project is completed and  
254.7 the number of days in the nursing facility's reporting period shall be 365.

254.8 (e) The value of assets to be recognized for a total replacement project as defined in  
254.9 section 256B.431, subdivision 17d, shall be computed as described in clause (1). The value  
254.10 of assets to be recognized for all other projects shall be computed as described in clause  
254.11 (2).

254.12 (1) Replacement-cost-new limits under section 256B.431, subdivision 17e, and the  
254.13 number of beds allowed under subdivision 3a, paragraph (c), shall be used to compute the  
254.14 maximum amount of assets allowable in a facility's property rate calculation. If a facility's  
254.15 current request for a rate adjustment results from the completion of a construction project  
254.16 that was previously approved under section 144A.073, the assets to be used in the rate  
254.17 calculation cannot exceed the lesser of the amount determined under sections 144A.071,  
254.18 subdivision 2, and 144A.073, subdivision 3b, or the actual allowable costs of the construction  
254.19 project. A current request that is not the result of a project under section 144A.073 cannot  
254.20 exceed the limit under section 144A.071, subdivision 2, paragraph ~~(a)~~ (c), clause (1).  
254.21 Applicable credits must be deducted from the cost of the construction project.

254.22 (2)(i) Replacement-cost-new limits under section 256B.431, subdivision 17e, and the  
254.23 number of beds allowed under section 256B.431, subdivision 3a, paragraph (c), shall be  
254.24 used to compute the maximum amount of assets allowable in a facility's property rate  
254.25 calculation.

254.26 (ii) The value of a facility's assets to be compared to the amount in item (i) begins with  
254.27 the total appraised value from the last rate notice a facility received when its rates were set  
254.28 under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080. This value  
254.29 shall be indexed by the factor in section 256B.431, subdivision 3f, paragraph (a), for each  
254.30 rate year the facility received an inflation factor on its property-related rate when its rates  
254.31 were set under this section. The value of assets listed as previous capital additions, capital  
254.32 additions, and special projects on the facility's base year rate notice and the value of assets  
254.33 related to a construction project for which the facility received a rate adjustment when its  
254.34 rates were determined under this section shall be added to the indexed appraised value.

255.1 (iii) The maximum amount of assets to be recognized in computing a facility's rate  
255.2 adjustment after a project is completed is the lesser of the aggregate replacement-cost-new  
255.3 limit computed in (i) minus the assets recognized in (ii) or the actual allowable costs of the  
255.4 construction project.

255.5 (iv) If a facility's current request for a rate adjustment results from the completion of a  
255.6 construction project that was previously approved under section 144A.073, the assets to be  
255.7 added to the rate calculation cannot exceed the lesser of the amount determined under  
255.8 sections 144A.071, subdivision 2, and 144A.073, subdivision 3b, or the actual allowable  
255.9 costs of the construction project. A current request that is not the result of a project under  
255.10 section 144A.073 cannot exceed the limit stated in section 144A.071, subdivision 2,  
255.11 paragraph ~~(a)~~ (c), clause (1). Assets disposed of as a result of a construction project and  
255.12 applicable credits must be deducted from the cost of the construction project.

255.13 (f) For construction projects approved under section 144A.073, allowable debt may  
255.14 never exceed the lesser of the cost of the assets purchased, the threshold limit in section  
255.15 144A.071, subdivision 2, or the replacement-cost-new limit less previously existing capital  
255.16 debt.

255.17 (g) For construction projects that were not approved under section 144A.073, allowable  
255.18 debt is limited to the lesser of the threshold in section 144A.071, subdivision 2, for such  
255.19 construction projects or the applicable limit in paragraph (e), clause (1) or (2), less previously  
255.20 existing capital debt. Amounts of debt taken out that exceed the costs of a construction  
255.21 project shall not be allowed regardless of the use of the funds.

255.22 For all construction projects being recognized, interest expense and average debt shall  
255.23 be computed based on the first 12 months following project completion. "Previously existing  
255.24 capital debt" means capital debt recognized on the last rate determined under section  
255.25 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, and the amount of debt  
255.26 recognized for a construction project for which the facility received a rate adjustment when  
255.27 its rates were determined under this section.

255.28 For a total replacement project as defined in section 256B.431, subdivision 17d, the  
255.29 value of previously existing capital debt shall be zero.

255.30 (h) In addition to the interest expense allowed from the application of paragraph (f), the  
255.31 amounts allowed under section 256B.431, subdivision 17a, paragraph (a), clauses (2) and  
255.32 (3), will be added to interest expense.

255.33 (i) The equity portion of the construction project shall be computed as the allowable  
255.34 assets in paragraph (e), less the average debt in paragraph (f). The equity portion must be

256.1 multiplied by 5.66 percent and the allowable interest expense in paragraph (f) must be added.  
256.2 This sum must be divided by 95 percent of capacity days to compute the construction project  
256.3 rate adjustment.

256.4 (j) For projects that are not a total replacement of a nursing facility, the amount in  
256.5 paragraph (i) is adjusted for nonreimbursable areas and then added to the current property  
256.6 payment rate of the facility.

256.7 (k) For projects that are a total replacement of a nursing facility, the amount in paragraph  
256.8 (i) becomes the new property payment rate after being adjusted for nonreimbursable areas.  
256.9 Any amounts existing in a facility's rate before the effective date of the construction project  
256.10 for equity incentives under section 256B.431, subdivision 16; capital repairs and replacements  
256.11 under section 256B.431, subdivision 15; or refinancing incentives under section 256B.431,  
256.12 subdivision 19, shall be removed from the facility's rates.

256.13 (l) No additional equipment allowance is allowed under Minnesota Rules, part 9549.0060,  
256.14 subpart 10, as the result of construction projects under this section. Allowable equipment  
256.15 shall be included in the construction project costs.

256.16 (m) Capital assets purchased after the completion date of a construction project shall be  
256.17 counted as construction project costs for any future rate adjustment request made by a facility  
256.18 under section 144A.071, subdivision 2, ~~clause (a)~~ paragraph (c), clause (1), if they are  
256.19 purchased within 24 months of the completion of the future construction project.

256.20 (n) In subsequent rate years, the property payment rate for a facility that results from  
256.21 the application of this subdivision shall be the amount inflated in subdivision 4.

256.22 (o) Construction projects are eligible for an equity incentive under section 256B.431,  
256.23 subdivision 16. When computing the equity incentive for a construction project under this  
256.24 subdivision, only the allowable costs and allowable debt related to the construction project  
256.25 shall be used. The equity incentive shall not be a part of the property payment rate and not  
256.26 inflated under subdivision 4. Effective October 1, 2006, all equity incentives for nursing  
256.27 facilities reimbursed under this section shall be allowed for a duration determined under  
256.28 section 256B.431, subdivision 16, paragraph (c).

256.29 Sec. 178. Minnesota Statutes 2022, section 256B.692, subdivision 2, is amended to read:

256.30 Subd. 2. **Duties of commissioner of health.** (a) Notwithstanding chapters 62D and 62N,  
256.31 a county that elects to purchase medical assistance in return for a fixed sum without regard  
256.32 to the frequency or extent of services furnished to any particular enrollee is not required to  
256.33 obtain a certificate of authority under chapter 62D or 62N. The county board of

257.1 commissioners is the governing body of a county-based purchasing program. In a multicounty  
257.2 arrangement, the governing body is a joint powers board established under section 471.59.

257.3 (b) A county that elects to purchase medical assistance services under this section must  
257.4 satisfy the commissioner of health that the requirements for assurance of consumer protection,  
257.5 provider protection, and fiscal solvency of chapter 62D, applicable to health maintenance  
257.6 organizations will be met according to the following schedule:

257.7 (1) for a county-based purchasing plan approved on or before June 30, 2008, the plan  
257.8 must have in reserve:

257.9 (i) at least 50 percent of the minimum amount required under chapter 62D as of January  
257.10 1, 2010;

257.11 (ii) at least 75 percent of the minimum amount required under chapter 62D as of January  
257.12 1, 2011;

257.13 (iii) at least 87.5 percent of the minimum amount required under chapter 62D as of  
257.14 January 1, 2012; and

257.15 (iv) at least 100 percent of the minimum amount required under chapter 62D as of January  
257.16 1, 2013; and

257.17 (2) for a county-based purchasing plan first approved after June 30, 2008, the plan must  
257.18 have in reserve:

257.19 (i) at least 50 percent of the minimum amount required under chapter 62D at the time  
257.20 the plan begins enrolling enrollees;

257.21 (ii) at least 75 percent of the minimum amount required under chapter 62D after the first  
257.22 full calendar year;

257.23 (iii) at least 87.5 percent of the minimum amount required under chapter 62D after the  
257.24 second full calendar year; and

257.25 (iv) at least 100 percent of the minimum amount required under chapter 62D after the  
257.26 third full calendar year.

257.27 (c) Until a plan is required to have reserves equaling at least 100 percent of the minimum  
257.28 amount required under chapter 62D, the plan may demonstrate its ability to cover any losses  
257.29 by satisfying the requirements of chapter 62N. A county-based purchasing plan must also  
257.30 assure the commissioner of health that the requirements of sections 62J.041; 62J.48; 62J.71  
257.31 to 62J.73; all applicable provisions of chapter 62Q, including sections 62Q.075; 62Q.1055;

258.1 62Q.106; 62Q.12; 62Q.135; 62Q.14; ~~62Q.145~~; 62Q.19; 62Q.23, paragraph (c); 62Q.43;  
258.2 62Q.47; 62Q.50; 62Q.52 to 62Q.56; 62Q.58; 62Q.68 to 62Q.72; and 72A.201 will be met.

258.3 (d) All enforcement and rulemaking powers available under chapters 62D, 62J, 62N,  
258.4 and 62Q are hereby granted to the commissioner of health with respect to counties that  
258.5 purchase medical assistance services under this section.

258.6 (e) The commissioner, in consultation with county government, shall develop  
258.7 administrative and financial reporting requirements for county-based purchasing programs  
258.8 relating to sections 62D.041, 62D.042, 62D.045, 62D.08, 62N.28, 62N.29, and 62N.31,  
258.9 and other sections as necessary, that are specific to county administrative, accounting, and  
258.10 reporting systems and consistent with other statutory requirements of counties.

258.11 (f) The commissioner shall collect from a county-based purchasing plan under this  
258.12 section the following fees:

258.13 (1) fees attributable to the costs of audits and other examinations of plan financial  
258.14 operations. These fees are subject to the provisions of Minnesota Rules, part 4685.2800,  
258.15 subpart 1, item F; and

258.16 (2) an annual fee of \$21,500, to be paid by June 15 of each calendar year.

258.17 All fees collected under this paragraph shall be deposited in the state government special  
258.18 revenue fund.

258.19 **EFFECTIVE DATE.** This section is effective the day following final enactment.

258.20 Sec. 179. Minnesota Statutes 2022, section 403.161, is amended to read:

258.21 **403.161 PREPAID WIRELESS FEES IMPOSED; COLLECTION; REMITTANCE.**

258.22 Subdivision 1. **Fees imposed.** (a) A prepaid wireless E911 fee of 80 cents per retail  
258.23 transaction is imposed on prepaid wireless telecommunications service until the fee is  
258.24 adjusted as an amount per retail transaction under subdivision 7.

258.25 (b) A prepaid wireless telecommunications access Minnesota fee, in the amount of the  
258.26 monthly charge provided for in section 237.52, subdivision 2, is imposed on each retail  
258.27 transaction for prepaid wireless telecommunications service until the fee is adjusted as an  
258.28 amount per retail transaction under subdivision 7.

258.29 (c) A prepaid wireless 988 fee, in the amount of the monthly charge, is imposed on each  
258.30 retail transaction for prepaid wireless telecommunications service until the fee is adjusted  
258.31 as an amount per retail transaction under subdivision 7.

259.1 Subd. 2. **Exemption.** The fees established under subdivision 1 are not imposed on a  
259.2 minimal amount of prepaid wireless telecommunications service that is sold with a prepaid  
259.3 wireless device and is charged a single nonitemized price, and a seller may not apply the  
259.4 fees to such a transaction. For purposes of this subdivision, a minimal amount of service  
259.5 means an amount of service denominated as either ten minutes or less or \$5 or less.

259.6 Subd. 3. **Fee collected.** The prepaid wireless E911 ~~and~~, telecommunications access  
259.7 Minnesota, and 988 fees must be collected by the seller from the consumer for each retail  
259.8 transaction occurring in this state. The amount of each fee must be combined into one  
259.9 amount, which must be separately stated on an invoice, receipt, or other similar document  
259.10 that is provided to the consumer by the seller.

259.11 Subd. 4. **Sales and use tax treatment.** For purposes of this section, a retail transaction  
259.12 conducted in person by a consumer at a business location of the seller must be treated as  
259.13 occurring in this state if that business location is in this state, and any other retail transaction  
259.14 must be treated as occurring in this state if the retail transaction is treated as occurring in  
259.15 this state for purposes of the sales and use tax as specified in section 297A.669, subdivision  
259.16 3, paragraph (c).

259.17 Subd. 5. **Remittance.** The prepaid wireless E911 ~~and~~, telecommunications access  
259.18 Minnesota, and 988 fees are the liability of the consumer and not of the seller or of any  
259.19 provider, except that the seller is liable to remit all fees as provided in section 403.162.

259.20 Subd. 6. **Exclusion for calculating other charges.** The combined amount of the prepaid  
259.21 wireless E911 ~~and~~, telecommunications access Minnesota, and 988 fees collected by a seller  
259.22 from a consumer must not be included in the base for measuring any tax, fee, surcharge, or  
259.23 other charge that is imposed by this state, any political subdivision of this state, or any  
259.24 intergovernmental agency.

259.25 Subd. 7. **Fee changes.** (a) The prepaid wireless E911 ~~and~~, telecommunications access  
259.26 Minnesota fee, and 988 fees must be proportionately increased or reduced upon any change  
259.27 to the fee imposed under section 403.11, subdivision 1, paragraph (c), after July 1, 2013,  
259.28 ~~or~~ the fee imposed under section 237.52, subdivision 2, or the fee imposed under section  
259.29 145.561, subdivision 4, as applicable.

259.30 (b) The department shall post notice of any fee changes on its website at least 30 days  
259.31 in advance of the effective date of the fee changes. It is the responsibility of sellers to monitor  
259.32 the department's website for notice of fee changes.

260.1 (c) Fee changes are effective 60 days after the first day of the first calendar month after  
260.2 the commissioner of public safety or the Public Utilities Commission, as applicable, changes  
260.3 the fee.

260.4 Sec. 180. Minnesota Statutes 2022, section 403.162, is amended to read:

260.5 **403.162 ADMINISTRATION OF PREPAID WIRELESS E911 FEES.**

260.6 Subdivision 1. **Remittance.** Prepaid wireless E911 ~~and~~<sub>2</sub> telecommunications access  
260.7 Minnesota, and 988 fees collected by sellers must be remitted to the commissioner of revenue  
260.8 at the times and in the manner provided by chapter 297A with respect to the general sales  
260.9 and use tax. The commissioner of revenue shall establish registration and payment procedures  
260.10 that substantially coincide with the registration and payment procedures that apply in chapter  
260.11 297A.

260.12 Subd. 2. **Seller's fee retention.** A seller may deduct and retain three percent of prepaid  
260.13 wireless E911 ~~and~~<sub>2</sub> telecommunications access Minnesota, and 988 fees collected by the  
260.14 seller from consumers.

260.15 Subd. 3. **Department of Revenue provisions.** The audit, assessment, appeal, collection,  
260.16 refund, penalty, interest, enforcement, and administrative provisions of chapters 270C and  
260.17 289A that are applicable to the taxes imposed by chapter 297A apply to any fee imposed  
260.18 under section 403.161.

260.19 Subd. 4. **Procedures for resale transactions.** The commissioner of revenue shall  
260.20 establish procedures by which a seller of prepaid wireless telecommunications service may  
260.21 document that a sale is not a retail transaction. These procedures must substantially coincide  
260.22 with the procedures for documenting sale for resale transactions as provided in chapter  
260.23 297A.

260.24 Subd. 5. **Fees deposited.** (a) The commissioner of revenue shall, based on the relative  
260.25 proportion of the prepaid wireless E911 fee ~~and~~<sub>2</sub> the prepaid wireless telecommunications  
260.26 access Minnesota fee, and the prepaid wireless 988 fee, imposed per retail transaction, divide  
260.27 the fees collected in corresponding proportions. Within 30 days of receipt of the collected  
260.28 fees, the commissioner shall:

260.29 (1) deposit the proportion of the collected fees attributable to the prepaid wireless E911  
260.30 fee in the 911 emergency telecommunications service account in the special revenue fund;  
260.31 ~~and~~

261.1 (2) deposit the proportion of collected fees attributable to the prepaid wireless  
261.2 telecommunications access Minnesota fee in the telecommunications access fund established  
261.3 in section 237.52, subdivision 1; and

261.4 (3) deposit the proportion of the collected fees attributable to the prepaid wireless 988  
261.5 fee in the 988 special revenue account established.

261.6 (b) The commissioner of revenue may deduct and deposit in a special revenue account  
261.7 an amount not to exceed two percent of collected fees. Money in the account is annually  
261.8 appropriated to the commissioner of revenue to reimburse its direct costs of administering  
261.9 the collection and remittance of prepaid wireless E911 fees, ~~and~~ prepaid wireless  
261.10 telecommunications access Minnesota fees, and prepaid wireless 988 fees.

261.11 Sec. 181. Minnesota Statutes 2022, section 518A.39, subdivision 2, is amended to read:

261.12 Subd. 2. **Modification.** (a) The terms of an order respecting maintenance or support  
261.13 may be modified upon a showing of one or more of the following, any of which makes the  
261.14 terms unreasonable and unfair: (1) substantially increased or decreased gross income of an  
261.15 obligor or obligee; (2) substantially increased or decreased need of an obligor or obligee or  
261.16 the child or children that are the subject of these proceedings; (3) receipt of assistance under  
261.17 the AFDC program formerly codified under sections 256.72 to 256.87 or 256B.01 to ~~256B.40~~  
261.18 256B.39, or chapter 256J or 256K; (4) a change in the cost of living for either party as  
261.19 measured by the federal Bureau of Labor Statistics; (5) extraordinary medical expenses of  
261.20 the child not provided for under section 518A.41; (6) a change in the availability of  
261.21 appropriate health care coverage or a substantial increase or decrease in health care coverage  
261.22 costs; (7) the addition of work-related or education-related child care expenses of the obligee  
261.23 or a substantial increase or decrease in existing work-related or education-related child care  
261.24 expenses; or (8) upon the emancipation of the child, as provided in subdivision 5.

261.25 (b) It is presumed that there has been a substantial change in circumstances under  
261.26 paragraph (a) and the terms of a current support order shall be rebuttably presumed to be  
261.27 unreasonable and unfair if:

261.28 (1) the application of the child support guidelines in section 518A.35, to the current  
261.29 circumstances of the parties results in a calculated court order that is at least 20 percent and  
261.30 at least \$75 per month higher or lower than the current support order or, if the current support  
261.31 order is less than \$75, it results in a calculated court order that is at least 20 percent per  
261.32 month higher or lower;

262.1 (2) the medical support provisions of the order established under section 518A.41 are  
262.2 not enforceable by the public authority or the obligee;

262.3 (3) health coverage ordered under section 518A.41 is not available to the child for whom  
262.4 the order is established by the parent ordered to provide;

262.5 (4) the existing support obligation is in the form of a statement of percentage and not a  
262.6 specific dollar amount;

262.7 (5) the gross income of an obligor or obligee has decreased by at least 20 percent through  
262.8 no fault or choice of the party; or

262.9 (6) a deviation was granted based on the factor in section 518A.43, subdivision 1, clause  
262.10 (4), and the child no longer resides in a foreign country or the factor is otherwise no longer  
262.11 applicable.

262.12 (c) A child support order is not presumptively modifiable solely because an obligor or  
262.13 obligee becomes responsible for the support of an additional nonjoint child, which is born  
262.14 after an existing order. Section 518A.33 shall be considered if other grounds are alleged  
262.15 which allow a modification of support.

262.16 (d) If child support was established by applying a parenting expense adjustment or  
262.17 presumed equal parenting time calculation under previously existing child support guidelines  
262.18 and there is no parenting plan or order from which overnights or overnight equivalents can  
262.19 be determined, there is a rebuttable presumption that the established adjustment or calculation  
262.20 will continue after modification so long as the modification is not based on a change in  
262.21 parenting time. In determining an obligation under previously existing child support  
262.22 guidelines, it is presumed that the court shall:

262.23 (1) if a 12 percent parenting expense adjustment was applied, multiply the obligor's  
262.24 share of the combined basic support obligation calculated under section 518A.34, paragraph  
262.25 (b), clause (5), by 0.88; or

262.26 (2) if the parenting time was presumed equal but the parents' parental incomes for  
262.27 determining child support were not equal:

262.28 (i) multiply the combined basic support obligation under section 518A.34, paragraph  
262.29 (b), clause (5), by 0.75;

262.30 (ii) prorate the amount under item (i) between the parents based on each parent's  
262.31 proportionate share of the combined PICS; and

262.32 (iii) subtract the lower amount from the higher amount.

263.1 (e) On a motion for modification of maintenance, including a motion for the extension  
263.2 of the duration of a maintenance award, the court shall apply, in addition to all other relevant  
263.3 factors, the factors for an award of maintenance under section 518.552 that exist at the time  
263.4 of the motion. On a motion for modification of support, the court:

263.5 (1) shall apply section 518A.35, and shall not consider the financial circumstances of  
263.6 each party's spouse, if any; and

263.7 (2) shall not consider compensation received by a party for employment in excess of a  
263.8 40-hour work week, provided that the party demonstrates, and the court finds, that:

263.9 (i) the excess employment began after entry of the existing support order;

263.10 (ii) the excess employment is voluntary and not a condition of employment;

263.11 (iii) the excess employment is in the nature of additional, part-time employment, or  
263.12 overtime employment compensable by the hour or fractions of an hour;

263.13 (iv) the party's compensation structure has not been changed for the purpose of affecting  
263.14 a support or maintenance obligation;

263.15 (v) in the case of an obligor, current child support payments are at least equal to the  
263.16 guidelines amount based on income not excluded under this clause; and

263.17 (vi) in the case of an obligor who is in arrears in child support payments to the obligee,  
263.18 any net income from excess employment must be used to pay the arrearages until the  
263.19 arrearages are paid in full.

263.20 (f) A modification of support or maintenance, including interest that accrued pursuant  
263.21 to section 548.091, may be made retroactive only with respect to any period during which  
263.22 the petitioning party has pending a motion for modification but only from the date of service  
263.23 of notice of the motion on the responding party and on the public authority if public assistance  
263.24 is being furnished or the county attorney is the attorney of record, unless the court adopts  
263.25 an alternative effective date under paragraph (l). The court's adoption of an alternative  
263.26 effective date under paragraph (l) shall not be considered a retroactive modification of  
263.27 maintenance or support.

263.28 (g) Except for an award of the right of occupancy of the homestead, provided in section  
263.29 518.63, all divisions of real and personal property provided by section 518.58 shall be final,  
263.30 and may be revoked or modified only where the court finds the existence of conditions that  
263.31 justify reopening a judgment under the laws of this state, including motions under section  
263.32 518.145, subdivision 2. The court may impose a lien or charge on the divided property at  
263.33 any time while the property, or subsequently acquired property, is owned by the parties or

264.1 either of them, for the payment of maintenance or support money, or may sequester the  
264.2 property as is provided by section 518A.71.

264.3 (h) The court need not hold an evidentiary hearing on a motion for modification of  
264.4 maintenance or support.

264.5 (i) Sections 518.14 and 518A.735 shall govern the award of attorney fees for motions  
264.6 brought under this subdivision.

264.7 (j) An enactment, amendment, or repeal of law constitutes a substantial change in the  
264.8 circumstances for purposes of modifying a child support order when it meets the standards  
264.9 for modification in this section.

264.10 (k) On the first modification following implementation of amended child support  
264.11 guidelines, the modification of basic support may be limited if the amount of the full variance  
264.12 would create hardship for either the obligor or the obligee. Hardship includes, but is not  
264.13 limited to, eligibility for assistance under chapter 256J.

264.14 (l) The court may select an alternative effective date for a maintenance or support order  
264.15 if the parties enter into a binding agreement for an alternative effective date.

264.16 **EFFECTIVE DATE.** This section is effective the day following final enactment.

264.17 Sec. 182. Laws 2017, First Special Session chapter 6, article 5, section 11, as amended  
264.18 by Laws 2019, First Special Session chapter 9, article 8, section 20, is amended to read:

264.19 **Sec. 11. MORATORIUM ON CONVERSION TRANSACTIONS.**

264.20 (a) Notwithstanding Laws 2017, chapter 2, article 2, a nonprofit health service plan  
264.21 corporation operating under Minnesota Statutes, chapter 62C, or a nonprofit health  
264.22 maintenance organization operating under Minnesota Statutes, chapter 62D, as of January  
264.23 1, 2017, may only merge or consolidate with; convert; or transfer, as part of a single  
264.24 transaction or a series of transactions within a 24-month period, all or a material amount of  
264.25 its assets to an entity that is a corporation organized under Minnesota Statutes, chapter  
264.26 317A; or to a Minnesota nonprofit hospital within the same integrated health system as the  
264.27 health maintenance organization. For purposes of this section, "material amount" means  
264.28 the lesser of ten percent of such an entity's total admitted net assets as of December 31 of  
264.29 the previous year, or \$50,000,000.

264.30 (b) Paragraph (a) does not apply if the nonprofit service plan corporation or nonprofit  
264.31 health maintenance organization files an intent to dissolve due to insolvency of the

265.1 corporation in accordance with Minnesota Statutes, chapter 317A, or insolvency proceedings  
265.2 are commenced under Minnesota Statutes, chapter 60B.

265.3 (c) Nothing in this section shall be construed to authorize a nonprofit health maintenance  
265.4 organization or a nonprofit service plan corporation to engage in any transaction or activities  
265.5 not otherwise permitted under state law.

265.6 (d) This section expires July 1, ~~2023~~ 2026.

265.7 **EFFECTIVE DATE.** This section is effective the day following final enactment.

265.8 Sec. 183. Laws 2022, chapter 99, article 1, section 46, is amended to read:

265.9 Sec. 46. **MENTAL HEALTH GRANTS FOR HEALTH CARE PROFESSIONALS.**

265.10 Subdivision 1. **Grants authorized.** (a) The commissioner of health shall develop a grant  
265.11 program to award grants to health care entities, including but not limited to health care  
265.12 systems, hospitals, nursing facilities, community health clinics or consortium of clinics,  
265.13 federally qualified health centers, rural health clinics, or health professional associations  
265.14 for the purpose of establishing or expanding programs focused on improving the mental  
265.15 health of health care professionals.

265.16 (b) Grants shall be awarded for programs that are evidenced-based or evidenced-informed  
265.17 and are focused on addressing the mental health of health care professionals by:

265.18 (1) identifying and addressing the barriers to and stigma among health care professionals  
265.19 associated with seeking self-care, including mental health and substance use disorder services;

265.20 (2) encouraging health care professionals to seek support and care for mental health and  
265.21 substance use disorder concerns;

265.22 (3) identifying risk factors associated with suicide and other mental health conditions;

265.23 ~~or~~

265.24 (4) developing and making available resources to support health care professionals with  
265.25 self-care and resiliency; or

265.26 (5) identifying and modifying structural barriers in health care delivery that create  
265.27 unnecessary stress in the workplace.

265.28 Subd. 2. **Allocation of grants.** (a) To receive a grant, a health care entity must submit  
265.29 an application to the commissioner by the deadline established by the commissioner. An  
265.30 application must be on a form and contain information as specified by the commissioner  
265.31 and at a minimum must contain:

- 266.1 (1) a description of the purpose of the program for which the grant funds will be used;
- 266.2 (2) a description of the achievable objectives of the program and how these objectives
- 266.3 will be met; and
- 266.4 (3) a process for documenting and evaluating the results of the program.

266.5 (b) The commissioner shall give priority to programs that involve peer-to-peer support.

266.6 Subd. 2a. **Grant term.** Notwithstanding Minnesota Statutes, section 16A.28, subdivision

266.7 6, encumbrances for grants under this section issued by June 30 of each year may be certified

266.8 for a period of up to three years beyond the year in which the funds were originally

266.9 appropriated.

266.10 Subd. 3. **Evaluation.** The commissioner shall evaluate the overall effectiveness of the

266.11 grant program by conducting a periodic evaluation of the impact and outcomes of the grant

266.12 program on health care professional burnout and retention. The commissioner shall submit

266.13 the results of the evaluation and any recommendations for improving the grant program to

266.14 the chairs and ranking minority members of the legislative committees with jurisdiction

266.15 over health care policy and finance by October 15, 2024.

266.16 Sec. 184. Laws 2022, chapter 99, article 3, section 9, is amended to read:

266.17 Sec. 9. **APPROPRIATION; MENTAL HEALTH GRANTS FOR HEALTH CARE**

266.18 **PROFESSIONALS.**

266.19 \$1,000,000 in fiscal year 2023 is appropriated from the general fund to the commissioner

266.20 of health for the health care professionals mental health grant program. This is a onetime

266.21 appropriation and is available until June 30, 2027.

266.22 **EFFECTIVE DATE.** This section is effective the day following final enactment.

266.23 Sec. 185. **ADOLESCENT MENTAL HEALTH PROMOTION; GRANTS**

266.24 **AUTHORIZED.**

266.25 Subdivision 1. **Goal and establishment.** (a) It is the goal of the state to increase protective

266.26 factors for mental well-being and decrease disparities in rates of mental health issues among

266.27 adolescent populations. The commissioner of health shall administer grants to

266.28 community-based organizations to facilitate mental health promotion programs for

266.29 adolescents, particularly those from populations that report higher rates of specific mental

266.30 health needs.

267.1 (b) The commissioner of health shall coordinate with other efforts at the local, state, or  
267.2 national level to avoid duplication and promote complementary efforts in mental health  
267.3 promotion among adolescents.

267.4 Subd. 2. **Grants authorized.** (a) The commissioner of health shall award grants to  
267.5 eligible community organizations, including nonprofit organizations, community health  
267.6 boards, and Tribal public health entities, to implement community-based mental health  
267.7 promotion programs for adolescents in community settings to improve adolescent mental  
267.8 health and reduce disparities between adolescent populations in reported rates of mental  
267.9 health needs.

267.10 (b) The commissioner of health, in collaboration with community and professional  
267.11 stakeholders, shall establish criteria for review of applications received under this subdivision  
267.12 to ensure funded programs operate using best practices such as trauma-informed care and  
267.13 positive youth development principles.

267.14 (c) Grant funds distributed under this subdivision shall be used to support new or existing  
267.15 community-based mental health promotion programs that include but are not limited to:

267.16 (1) training community-based members to facilitate discussions or courses on adolescent  
267.17 mental health promotion skills;

267.18 (2) training trusted community members to model positive mental health skills and  
267.19 practices in their existing roles;

267.20 (3) training and supporting adolescents to provide peer support; and

267.21 (4) supporting community dialogue on mental health promotion and collective stress or  
267.22 trauma.

267.23 Subd. 3. **Evaluation.** The commissioner shall conduct an evaluation of the  
267.24 community-based grant programs funded under this section. Grant recipients shall cooperate  
267.25 with the commissioner in the evaluation, and at the direction of the commissioner, shall  
267.26 provide the commissioner with the information needed to conduct the evaluation.

267.27 Sec. 186. **ADVANCING HEALTH EQUITY THROUGH CAPACITY BUILDING**  
267.28 **AND RESOURCE ALLOCATION.**

267.29 Subdivision 1. **Establishment of grant program.** The commissioner of health shall:

267.30 (1) establish an annual grant program to award infrastructure capacity building grants  
267.31 to help metro and rural community and faith-based organizations serving populations of  
267.32 color, American Indians, LGBTQIA+ communities, and those with disabilities in Minnesota

268.1 who have been disproportionately impacted by health and other inequities to be better  
268.2 equipped and prepared for success in procuring grants and contracts at the department and  
268.3 addressing inequities; and

268.4 (2) create a framework at the department to maintain equitable practices in grantmaking  
268.5 to ensure that internal grantmaking and procurement policies and practices prioritize equity,  
268.6 transparency, and accessibility to include:

268.7 (i) a tracking system for the department to better monitor and evaluate equitable  
268.8 procurement and grantmaking processes and their impacts; and

268.9 (ii) technical assistance and coaching to department leadership in grantmaking and  
268.10 procurement processes and programs and providing tools and guidance to ensure equitable  
268.11 and transparent competitive grantmaking processes and award distribution across  
268.12 communities most impacted by inequities and develop measures to track progress over time.

268.13 Subd. 2. Commissioner's duties. The commissioner of health shall:

268.14 (1) in consultation with community stakeholders, community health boards, and Tribal  
268.15 nations, develop a request for proposals for an infrastructure capacity building grant program  
268.16 to help community-based organizations, including faith-based organizations, to be better  
268.17 equipped and prepared for success in procuring grants and contracts at the department and  
268.18 beyond;

268.19 (2) provide outreach, technical assistance, and program development support to increase  
268.20 capacity for new and existing community-based organizations and other service providers  
268.21 in order to better meet statewide needs particularly in greater Minnesota and areas where  
268.22 services to reduce health disparities have not been established;

268.23 (3) in consultation with community stakeholders, review responses to requests for  
268.24 proposals and award grants under this section;

268.25 (4) ensure communication with the ethnic councils, Minnesota Indian Affairs Council,  
268.26 Minnesota Council on Disability, and the governor's office on the request for proposal  
268.27 process;

268.28 (5) in consultation with community stakeholders, establish a transparent and objective  
268.29 accountability process focused on outcomes that grantees agree to achieve;

268.30 (6) maintain data on outcomes reported by grantees; and

269.1 (7) establish a process or mechanism to evaluate the success of the capacity building  
269.2 grant program and to build the evidence base for effective community-based organizational  
269.3 capacity building in reducing disparities.

269.4 Subd. 3. **Eligible grantees.** Organizations eligible to receive grant funding under this  
269.5 section include: organizations or entities that work with diverse communities such as  
269.6 populations of color, American Indians, LGBTQIA+ communities, and those with disabilities  
269.7 in metro and rural communities.

269.8 Subd. 4. **Strategic consideration and priority of proposals; eligible populations;**  
269.9 **grant awards.** (a) The commissioner, in consultation with community stakeholders, shall  
269.10 develop a request for proposals for equity in procurement and grantmaking capacity building  
269.11 grant program to help community-based organizations, including faith-based organizations  
269.12 to be better equipped and prepared for success in procuring grants and contracts at the  
269.13 department and addressing inequities.

269.14 (b) In awarding the grants, the commissioner shall provide strategic consideration and  
269.15 give priority to proposals from organizations or entities led by populations of color or  
269.16 American Indians, and those serving communities of color, American Indians, LGBTQIA+  
269.17 communities, and disability communities.

269.18 Subd. 5. **Geographic distribution of grants.** The commissioner shall ensure that grant  
269.19 funds are prioritized and awarded to organizations and entities that are within counties that  
269.20 have a higher proportion of Black or African American, nonwhite Latino(a), LGBTQIA+,  
269.21 and disability communities to the extent possible.

269.22 Subd. 6. **Report.** Grantees must report grant program outcomes to the commissioner on  
269.23 the forms and according to the timelines established by the commissioner.

269.24 **Sec. 187. CRITICAL ACCESS DENTAL INFRASTRUCTURE PROGRAM.**

269.25 Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have  
269.26 the meanings given.

269.27 (b) "Commissioner" means the commissioner of health.

269.28 (c) "Critical access dental provider" means a critical access dental provider as defined  
269.29 in Minnesota Statutes, section 256B.76, subdivision 4.

269.30 (d) "Dental infrastructure" means:

269.31 (1) physical infrastructure of a dental setting, including but not limited to the operations  
269.32 and clinical spaces in a dental clinic; associated heating, ventilation, and air conditioning

270.1 infrastructure and other mechanical infrastructure; and dental equipment needed to operate  
270.2 a dental clinic; or

270.3 (2) mobile dental equipment or other equipment needed to provide dental services via  
270.4 a hub-and-spoke service delivery model or via teledentistry.

270.5 Subd. 2. **Grant and loan program established.** The commissioner shall make grants  
270.6 and forgivable loans to critical access dental providers for eligible dental infrastructure  
270.7 projects.

270.8 Subd. 3. **Eligible projects.** In order to be eligible for a grant or forgivable loan under  
270.9 this section, a dental infrastructure project must be proposed by a critical access dental  
270.10 provider and must allow the provider to maintain or expand the provider's capacity to serve  
270.11 Minnesota health care program enrollees.

270.12 Subd. 4. **Application.** (a) The commissioner must develop forms and procedures for  
270.13 soliciting and reviewing applications for grants and forgivable loans under this section and  
270.14 for awarding grants and forgivable loans. Critical access dental providers seeking a grant  
270.15 or forgivable loan under this section must apply to the commissioner in a time and manner  
270.16 specified by the commissioner. In evaluating applications for grants or forgivable loans for  
270.17 eligible projects, the commissioner must review applications for completeness and must  
270.18 determine the extent to which:

270.19 (1) the project would ensure that the critical access dental provider is able to continue  
270.20 to serve Minnesota health care program enrollees in a manner that would not be possible  
270.21 but for the project; or

270.22 (2) the project would increase the number of Minnesota health care program enrollees  
270.23 served by the provider or the clinical complexity of the Minnesota health care program  
270.24 enrollees served by the provider.

270.25 (b) The commissioner must award grants and forgivable loans based on the information  
270.26 provided in the grant application.

270.27 Subd. 5. **Program oversight.** The commissioner may require and collect from grant and  
270.28 loan recipients any information needed to evaluate the program.

270.29 Sec. 188. **DIRECTION TO COMMISSIONER OF HEALTH; DEVELOPMENT**  
270.30 **OF ANALYTICAL TOOLS.**

270.31 (a) The commissioner of health, in consultation with the Minnesota Nurses Association  
270.32 and other professional nursing organizations, must develop a means of analyzing available

271.1 adverse event data, available staffing data, and available data from concern for safe staffing  
271.2 forms to examine potential causal links between adverse events and understaffing.

271.3 (b) The commissioner must develop an initial means of conducting the analysis described  
271.4 in paragraph (a) by January 1, 2025, and publish a public report on the commissioner's  
271.5 initial findings by January 1, 2026.

271.6 (c) By January 1, 2024, the commissioner must submit to the chairs and ranking minority  
271.7 members of the house and senate committees with jurisdiction over the regulation of hospitals  
271.8 a report on the available data, potential sources of additional useful data, and any additional  
271.9 statutory authority the commissioner requires to collect additional useful information from  
271.10 hospitals.

271.11 **EFFECTIVE DATE.** This section is effective August 1, 2023.

271.12 Sec. 189. **DIRECTION TO COMMISSIONER OF HEALTH; NURSING**  
271.13 **WORKFORCE REPORT.**

271.14 (a) The commissioner of health must publish a public report on the current status of the  
271.15 state's nursing workforce employed by hospitals. In preparing the report, the commissioner  
271.16 shall utilize information collected in collaboration with the Board of Nursing as directed  
271.17 under Minnesota Statutes, sections 144.051 and 144.052, on Minnesota's supply of active  
271.18 licensed nurses and reasons licensed nurses are leaving direct care positions at hospitals;  
271.19 information collected and shared by the Minnesota Hospital Association on retention by  
271.20 hospitals of licensed nurses; information collected through an independent study on reasons  
271.21 licensed nurses are choosing not to renew their licenses and leaving the profession; and  
271.22 other publicly available data the commissioner deems useful.

271.23 (b) The commissioner must publish the report by January 1, 2026.

271.24 Sec. 190. **EMMETT LOUIS TILL VICTIMS RECOVERY PROGRAM.**

271.25 Subdivision 1. **Short title.** This section shall be known as the Emmett Louis Till Victims  
271.26 Recovery Program.

271.27 Subd. 2. **Program established; grants.** (a) The commissioner of health shall establish  
271.28 the Emmett Louis Till Victims Recovery Program to address the health and wellness needs  
271.29 of:

271.30 (1) victims who experienced trauma, including historical trauma, resulting from events  
271.31 such as assault or another violent physical act, intimidation, false accusations, wrongful

272.1 conviction, a hate crime, the violent death of a family member, or experiences of  
272.2 discrimination or oppression based on the victim's race, ethnicity, or national origin; and

272.3 (2) the families and heirs of victims described in clause (1), who experienced trauma,  
272.4 including historical trauma, because of their proximity or connection to the victim.

272.5 (b) The commissioner, in consultation with victims, families, and heirs described in  
272.6 paragraph (a), shall award competitive grants to applicants for projects to provide the  
272.7 following services to victims, families, and heirs described in paragraph (a):

272.8 (1) health and wellness services, which may include services and support to address  
272.9 physical health, mental health, and cultural needs;

272.10 (2) remembrance and legacy preservation activities;

272.11 (3) cultural awareness services; and

272.12 (4) community resources and services to promote healing for victims, families, and heirs  
272.13 described in paragraph (a).

272.14 (c) In awarding grants under this section, the commissioner must prioritize grant awards  
272.15 to community-based organizations experienced in providing support and services to victims,  
272.16 families, and heirs described in paragraph (a).

272.17 Subd. 3. **Evaluation.** Grant recipients must provide the commissioner with information  
272.18 required by the commissioner to evaluate the grant program, in a time and manner specified  
272.19 by the commissioner.

272.20 Subd. 4. **Reports.** The commissioner must submit a status report by January 15, 2024,  
272.21 and an additional report by January 15, 2025, on the operation and results of the grant  
272.22 program, to the extent available. These reports must be submitted to the chairs and ranking  
272.23 minority members of the legislative committees with jurisdiction over health care. The  
272.24 report due January 15, 2024, must include information on grant program activities to date  
272.25 and an assessment of the need to continue to offer services provided by grant recipients to  
272.26 victims, families, and heirs who experienced trauma resulting from government-sponsored  
272.27 activities. The report due January 15, 2025, must include a summary of the services offered  
272.28 by grant recipients; an assessment of the need to continue to offer services provided by  
272.29 grant recipients to victims, families, and heirs described in subdivision 2, paragraph (a);  
272.30 and an evaluation of the grant program's goals and outcomes.

273.1 Sec. 191. **HEALTHY BEGINNINGS, HEALTHY FAMILIES ACT.**

273.2 **Subdivision 1. Purpose.** The purpose of the Healthy Beginnings, Healthy Families Act  
273.3 is to build equitable, inclusive, and culturally and linguistically responsive systems that  
273.4 ensure the health and well-being of young children and their families by supporting the  
273.5 Minnesota perinatal quality collaborative, establishing the Minnesota partnership to prevent  
273.6 infant mortality, increasing access to culturally relevant developmental and social-emotional  
273.7 screening with follow-up, and sustaining and expanding the model jail practices for children  
273.8 of incarcerated parents in Minnesota jails.

273.9 **Subd. 2. Minnesota perinatal quality collaborative.** The Minnesota perinatal quality  
273.10 collaborative is established to improve pregnancy outcomes for pregnant people and  
273.11 newborns through efforts to:

273.12 (1) advance evidence-based and evidence-informed clinics and other health service  
273.13 practices and processes through quality care review, chart audits, and continuous quality  
273.14 improvement initiatives that enable equitable outcomes;

273.15 (2) review current data, trends, and research on best practices to inform and prioritize  
273.16 quality improvement initiatives;

273.17 (3) identify methods that incorporate antiracism into individual practice and organizational  
273.18 guidelines in the delivery of perinatal health services;

273.19 (4) support quality improvement initiatives to address substance use disorders in pregnant  
273.20 people and infants with neonatal abstinence syndrome or other effects of substance use;

273.21 (5) provide a forum to discuss state-specific system and policy issues to guide quality  
273.22 improvement efforts that improve population-level perinatal outcomes;

273.23 (6) reach providers and institutions in a multidisciplinary, collaborative, and coordinated  
273.24 effort across system organizations to reinforce a continuum of care model; and

273.25 (7) support health care facilities in monitoring interventions through rapid data collection  
273.26 and applying system changes to provide improved care in perinatal health.

273.27 **Subd. 3. Eligible organizations.** The commissioner of health shall make a grant to a  
273.28 nonprofit organization to create or sustain a multidisciplinary network of representatives  
273.29 of health care systems, health care providers, academic institutions, local and state agencies,  
273.30 and community partners that will collaboratively improve pregnancy and infant outcomes  
273.31 through evidence-based, population-level quality improvement initiatives.

274.1 Subd. 4. **Grants authorized.** The commissioner shall award one grant to a nonprofit  
274.2 organization to support efforts that improve maternal and infant health outcomes aligned  
274.3 with the purpose outlined in subdivision 2. The commissioner shall give preference to a  
274.4 nonprofit organization that has the ability to provide these services throughout the state.  
274.5 The commissioner shall provide content expertise to the grant recipient to further the  
274.6 accomplishment of the purpose.

274.7 Subd. 5. **Minnesota partnership to prevent infant mortality program.** (a) The  
274.8 commissioner of health shall establish the Minnesota partnership to prevent infant mortality  
274.9 program that is a statewide partnership program to engage communities, exchange best  
274.10 practices, share summary data on infant health, and promote policies to improve birth  
274.11 outcomes and eliminate preventable infant mortality.

274.12 (b) The goals of the Minnesota partnership to prevent infant mortality program are to:

274.13 (1) build a statewide multisectoral partnership including the state government, local  
274.14 public health agencies, Tribes, private sector, and community nonprofit organizations with  
274.15 the shared goal of decreasing infant mortality rates among populations with significant  
274.16 disparities, including among Black, American Indian, and other nonwhite communities,  
274.17 and rural populations;

274.18 (2) address the leading causes of poor infant health outcomes such as premature birth,  
274.19 infant sleep-related deaths, and congenital anomalies through strategies to change social  
274.20 and environmental determinants of health; and

274.21 (3) promote the development, availability, and use of data-informed, community-driven  
274.22 strategies to improve infant health outcomes.

274.23 Subd. 5a. **Grants authorized.** (a) The commissioner of health shall award grants to  
274.24 eligible applicants to convene, coordinate, and implement data-driven strategies and culturally  
274.25 relevant activities to improve infant health by reducing preterm births, sleep-related infant  
274.26 deaths, and congenital malformations and address social and environmental determinants  
274.27 of health. Grants shall be awarded to support community nonprofit organizations, Tribal  
274.28 governments, and community health boards. In accordance with available funding, grants  
274.29 shall be noncompetitively awarded to the eleven sovereign Tribal governments if their  
274.30 respective proposals demonstrate the ability to implement programs designed to achieve  
274.31 the purposes in subdivision 5 and meet other requirements of this section. An eligible  
274.32 applicant must submit a complete application to the commissioner of health by the deadline  
274.33 established by the commissioner. The commissioner shall award all other grants competitively

275.1 to eligible applicants in metropolitan and rural areas of the state and may consider geographic  
275.2 representation in grant awards.

275.3 (b) Grantee activities shall:

275.4 (1) address the leading cause or causes of infant mortality;

275.5 (2) be based on community input;

275.6 (3) focus on policy, systems, and environmental changes that support infant health; and

275.7 (4) address the health disparities and inequities that are experienced in the grantee's  
275.8 community.

275.9 (c) The commissioner shall review each application to determine whether the application  
275.10 is complete and whether the applicant and the project are eligible for a grant. In evaluating  
275.11 applications according to subdivision 5, the commissioner shall establish criteria including  
275.12 but not limited to: the eligibility of the applicant's project under this section; the applicant's  
275.13 thoroughness and clarity in describing the infant health issues grant funds are intended to  
275.14 address; a description of the applicant's proposed project; the project's likelihood to achieve  
275.15 the grant's purposes as described in this section; a description of the population demographics  
275.16 and service area of the proposed project; and evidence of efficiencies and effectiveness  
275.17 gained through collaborative efforts.

275.18 (d) Grant recipients shall report their activities to the commissioner in a format and at  
275.19 a time specified by the commissioner.

275.20 Subd. 5b. **Technical assistance.** (a) The commissioner shall provide content expertise,  
275.21 technical expertise, training to grant recipients, and advice on data-driven strategies.

275.22 (b) For the purposes of carrying out the grant program under subdivision 5, including  
275.23 for administrative purposes, the commissioner shall award contracts to appropriate entities  
275.24 to assist in training and provide technical assistance to grantees.

275.25 (c) Contracts awarded under paragraph (b) may be used to provide technical assistance  
275.26 and training in the areas of:

275.27 (1) partnership development and capacity building;

275.28 (2) Tribal support;

275.29 (3) implementation support for specific infant health strategies;

275.30 (4) communications by convening and sharing lessons learned; and

275.31 (5) health equity.

276.1 Subd. 6. **Developmental and social-emotional screening with follow-up.** The goal of  
276.2 the developmental and social-emotional screening is to identify young children at risk for  
276.3 developmental and behavioral concerns and provide follow-up services to connect families  
276.4 and young children to appropriate community-based resources and programs. The  
276.5 commissioner of health shall work with the commissioners of human services and education  
276.6 to implement this section and promote interagency coordination with other early childhood  
276.7 programs including those that provide screening and assessment.

276.8 Subd. 6a. **Duties.** The commissioner shall:

276.9 (1) increase the awareness of developmental and social-emotional screening with  
276.10 follow-up in coordination with community and state partners;

276.11 (2) expand existing electronic screening systems to administer developmental and  
276.12 social-emotional screening to children birth to kindergarten entrance;

276.13 (3) provide screening for developmental and social-emotional delays based on current  
276.14 recommended best practices;

276.15 (4) review and share the results of the screening with the parent or guardian. Support  
276.16 families in their role as caregivers by providing anticipatory guidance around typical growth  
276.17 and development;

276.18 (5) ensure children and families are referred to and linked with appropriate  
276.19 community-based services and resources when any developmental or social-emotional  
276.20 concerns are identified through screening; and

276.21 (6) establish performance measures and collect, analyze, and share program data regarding  
276.22 population-level outcomes of developmental and social-emotional screening, referrals to  
276.23 community-based services, and follow-up services.

276.24 Subd. 6b. **Grants authorized.** The commissioner shall award grants to community-based  
276.25 organizations, community health boards, and Tribal nations to support follow-up services  
276.26 for children with developmental or social-emotional concerns identified through screening  
276.27 in order to link children and their families to appropriate community-based services and  
276.28 resources. Grants shall also be awarded to community-based organizations to train and  
276.29 utilize cultural liaisons to help families navigate the screening and follow-up process in a  
276.30 culturally and linguistically responsive manner. The commissioner shall provide technical  
276.31 assistance, content expertise, and training to grant recipients to ensure that follow-up services  
276.32 are effectively provided.

277.1 Subd. 7. **Model jail practices for incarcerated parents.** (a) The commissioner of health  
277.2 may make special grants to counties and groups of counties to implement model jail practices  
277.3 and to county governments, Tribal governments, or nonprofit organizations in corresponding  
277.4 geographic areas to build partnerships with county jails to support children of incarcerated  
277.5 parents and their caregivers.

277.6 (b) "Model jail practices" means a set of practices that correctional administrators can  
277.7 implement to remove barriers that may prevent children from cultivating or maintaining  
277.8 relationships with their incarcerated parents during and immediately after incarceration  
277.9 without compromising safety or security of the correctional facility.

277.10 Subd. 7a. **Grants authorized; model jail practices.** (a) The commissioner of health  
277.11 shall award grants to eligible county jails to implement model jail practices and separate  
277.12 grants to county governments, Tribal governments, or nonprofit organizations in  
277.13 corresponding geographic areas to build partnerships with county jails to support children  
277.14 of incarcerated parents and their caregivers.

277.15 (b) Grantee activities include but are not limited to:

277.16 (1) parenting classes or groups;

277.17 (2) family-centered intake and assessment of inmate programs;

277.18 (3) family notification, information, and communication strategies;

277.19 (4) correctional staff training;

277.20 (5) policies and practices for family visits; and

277.21 (6) family-focused reentry planning.

277.22 (c) Grant recipients shall report their activities to the commissioner in a format and at a  
277.23 time specified by the commissioner.

277.24 Subd. 7b. **Technical assistance and oversight; model jail practices.** (a) The  
277.25 commissioner shall provide content expertise, training to grant recipients, and advice on  
277.26 evidence-based strategies, including evidence-based training to support incarcerated parents.

277.27 (b) For the purposes of carrying out the grant program under subdivision 7a, including  
277.28 for administrative purposes, the commissioner shall award contracts to appropriate entities  
277.29 to assist in training and provide technical assistance to grantees.

277.30 (c) Contracts awarded under paragraph (b) may be used to provide technical assistance  
277.31 and training in the areas of:

- 278.1 (1) evidence-based training for incarcerated parents;  
278.2 (2) partnership building and community engagement;  
278.3 (3) evaluation of process and outcomes of model jail practices; and  
278.4 (4) expert guidance on reducing the harm caused to children of incarcerated parents and  
278.5 application of model jail practices.

278.6 Sec. 192. **INITIAL IMPLEMENTATION OF THE KEEPING NURSES AT THE**  
278.7 **BEDSIDE ACT.**

278.8 (a) By October 1, 2024, each hospital must establish and convene a hospital nurse staffing  
278.9 committee as described under Minnesota Statutes, section 144.7053, and a hospital nurse  
278.10 workload committee as described under Minnesota Statutes, section 144.7054.

278.11 (b) By October 1, 2025, each hospital must implement core staffing plans developed by  
278.12 its hospital nurse staffing committee and satisfy the plan posting requirements under  
278.13 Minnesota Statutes, section 144.7056.

278.14 (c) By October 1, 2025, each hospital must submit to the commissioner of health core  
278.15 staffing plans meeting the requirements of Minnesota Statutes, section 144.7055.

278.16 (d) By October 1, 2025, the commissioner of health must develop a standard concern  
278.17 for safe staffing form and provide an electronic means of submitting the form to the relevant  
278.18 hospital nurse staffing committee. The commissioner must base the form on the existing  
278.19 concern for safe staffing form maintained by the Minnesota Nurses' Association.

278.20 (e) By January 1, 2026, the commissioner of health must provide electronic access to  
278.21 the uniform format or standard form for nurse staffing reporting described under Minnesota  
278.22 Statutes, section 144.7057, subdivision 4.

278.23 Sec. 193. **LONG COVID.**

278.24 Subdivision 1. **Definition.** For the purpose of this section, "long COVID" means health  
278.25 problems that people experience four or more weeks after being infected with SARS-CoV-2,  
278.26 the virus that causes COVID-19. Long COVID is also called post COVID conditions,  
278.27 long-haul COVID, chronic COVID, post-acute COVID, or post-acute sequelae of COVID-19  
278.28 (PASC).

278.29 Subd. 2. **Establishment.** The commissioner of health shall establish a program to conduct  
278.30 community assessments and epidemiologic investigations to monitor and address impacts  
278.31 of long COVID. The purposes of these activities are to:

279.1 (1) monitor trends in: incidence, prevalence, mortality, and health outcomes; care  
279.2 management and costs; changes in disability status, employment, and quality of life; and  
279.3 service needs of individuals with long COVID and to detect potential public health problems,  
279.4 predict risks, and assist in investigating long COVID health inequities;

279.5 (2) more accurately target information and resources for communities and patients and  
279.6 their families;

279.7 (3) inform health professionals and citizens about risks, early detection, and treatment  
279.8 of long COVID known to be elevated in their communities; and

279.9 (4) promote evidence-based practices around long COVID prevention and management  
279.10 and to address public concerns and questions about long COVID.

279.11 Subd. 3. **Partnerships.** The commissioner of health shall, in consultation with health  
279.12 care professionals, the Department of Human Services, local public health, health insurers,  
279.13 employers, schools, long COVID survivors, and community organizations serving people  
279.14 at high risk of long COVID, identify priority actions and activities to address the needs for  
279.15 communication, services, resources, tools, strategies, and policies to support long COVID  
279.16 survivors and their families.

279.17 Subd. 4. **Grants and contracts.** The commissioner of health shall coordinate and  
279.18 collaborate with community and organizational partners to implement evidence-informed  
279.19 priority actions through community-based grants and contracts. The commissioner of health  
279.20 shall award contracts and grants to organizations that serve communities disproportionately  
279.21 impacted by COVID-19 and long COVID, including but not limited to rural and low-income  
279.22 areas, Black and African Americans, African immigrants, American Indians, Asian  
279.23 American-Pacific Islanders, Latino(a) communities, LGBTQ+ communities, and persons  
279.24 with disabilities. Organizations may also address intersectionality within the groups. The  
279.25 commissioner shall award grants and contracts to eligible organizations to plan, construct,  
279.26 and disseminate resources and information to support survivors of long COVID, including  
279.27 caregivers, health care providers, ancillary health care workers, workplaces, schools,  
279.28 communities, and local and Tribal public health.

279.29 Sec. 194. **MEMBERSHIP TERMS; PALLIATIVE CARE ADVISORY COUNCIL.**

279.30 Notwithstanding the terms of office specified to the members upon their appointment,  
279.31 the terms for members appointed to the Palliative Care Advisory Council under Minnesota  
279.32 Statutes, section 144.059, on or after February 1, 2022, shall be three years, as provided in  
279.33 Minnesota Statutes, section 144.059, subdivision 3.

280.1 Sec. 195. **REPORT ON TRANSPARENCY OF HEALTH CARE PAYMENTS.**

280.2 **Subdivision 1. Definitions.** (a) The terms defined in this subdivision apply to this section.

280.3 (b) "Commissioner" means the commissioner of health.

280.4 (c) "Nonclaims-based payments" means payments to health care providers designed to  
280.5 support and reward value of health care services over volume of health care services and  
280.6 includes alternative payment models or incentives, payments for infrastructure expenditures  
280.7 or investments, and payments for workforce expenditures or investments.

280.8 (d) "Nonpublic data" has the meaning given in Minnesota Statutes, section 13.02,  
280.9 subdivision 9.

280.10 (e) "Primary care services" means integrated, accessible health care services provided  
280.11 by clinicians who are accountable for addressing a large majority of personal health care  
280.12 needs, developing a sustained partnership with patients, and practicing in the context of  
280.13 family and community. Primary care services include but are not limited to preventive  
280.14 services, office visits, administration of vaccines, annual physicals, pre-operative physicals,  
280.15 assessments, care coordination, development of treatment plans, management of chronic  
280.16 conditions, and diagnostic tests.

280.17 **Subd. 2. Report.** (a) To provide the legislature with information needed to meet the  
280.18 evolving health care needs of Minnesotans, the commissioner shall report to the legislature  
280.19 by February 15, 2024, on the volume and distribution of health care spending across payment  
280.20 models used by health plan companies and third-party administrators, with a particular focus  
280.21 on value-based care models and primary care spending.

280.22 (b) The report must include specific health plan and third-party administrator estimates  
280.23 of health care spending for claims-based payments and nonclaims-based payments for the  
280.24 most recent available year, reported separately for Minnesotans enrolled in state health care  
280.25 programs, Medicare Advantage, and commercial health insurance. The report must also  
280.26 include recommendations on changes needed to gather better data from health plan companies  
280.27 and third-party administrators on the use of value-based payments that pay for value of  
280.28 health care services provided over volume of services provided, promote the health of all  
280.29 Minnesotans, reduce health disparities, and support the provision of primary care services  
280.30 and preventive services.

280.31 (c) In preparing the report, the commissioner shall:

- 281.1 (1) describe the form, manner, and timeline for submission of data by health plan  
281.2 companies and third-party administrators to produce estimates as specified in paragraph  
281.3 (b);
- 281.4 (2) collect summary data that permits the computation of:
- 281.5 (i) the percentage of total payments that are nonclaims-based payments; and  
281.6 (ii) the percentage of payments in item (i) that are for primary care services;
- 281.7 (3) where data was not directly derived, specify the methods used to estimate data  
281.8 elements;
- 281.9 (4) notwithstanding Minnesota Statutes, section 62U.04, subdivision 11, conduct analyses  
281.10 of the magnitude of primary care payments using data collected by the commissioner under  
281.11 Minnesota Statutes, section 62U.04; and
- 281.12 (5) conduct interviews with health plan companies and third-party administrators to  
281.13 better understand the types of nonclaims-based payments and models in use, the purposes  
281.14 or goals of each, the criteria for health care providers to qualify for these payments, and the  
281.15 timing and structure of health plan companies or third-party administrators making these  
281.16 payments to health care provider organizations.
- 281.17 (d) Health plan companies and third-party administrators must comply with data requests  
281.18 from the commissioner under this section within 60 days after receiving the request.
- 281.19 (e) Data collected under this section is nonpublic data. Notwithstanding the definition  
281.20 of summary data in Minnesota Statutes, section 13.02, subdivision 19, summary data prepared  
281.21 under this section may be derived from nonpublic data. The commissioner shall establish  
281.22 procedures and safeguards to protect the integrity and confidentiality of any data maintained  
281.23 by the commissioner.
- 281.24 **Sec. 196. RETURN OF CHARITABLE ASSETS.**
- 281.25 If a health system that is organized as a charitable organization, and that includes M  
281.26 Health Fairview University of Minnesota Medical Center, sells or transfers control to an  
281.27 out-of-state nonprofit entity or to any for-profit entity, the health system must return to the  
281.28 general fund any charitable assets the health system received from the state.
- 281.29 **EFFECTIVE DATE.** This section is effective the day following final enactment and  
281.30 applies to transactions completed on or after that date.

282.1 Sec. 197. STUDY AND RECOMMENDATIONS; NONPROFIT HEALTH  
282.2 MAINTENANCE ORGANIZATION CONVERSIONS AND OTHER  
282.3 TRANSACTIONS.

282.4 (a) The commissioner of health shall study and develop recommendations on the  
282.5 regulation of conversions, mergers, transfers of assets, and other transactions affecting  
282.6 Minnesota-domiciled nonprofit health maintenance organizations and for-profit health  
282.7 maintenance organizations. The recommendations must at least address:

282.8 (1) monitoring and regulation of Minnesota-domiciled for-profit health maintenance  
282.9 organizations;

282.10 (2) issues related to public benefit assets held by a nonprofit health maintenance  
282.11 organization, including identifying the portion of the organization's assets that are considered  
282.12 public benefit assets to be protected, establishing a fair and independent process to value  
282.13 to the assets, and how public benefit assets should be stewarded for the public good;

282.14 (3) designating a state agency or executive branch office with authority to review and  
282.15 approve or deny a nonprofit health maintenance organization's plan to convert to a for-profit  
282.16 organization; and

282.17 (4) establishing a process for the public to learn about and provide input on a nonprofit  
282.18 health maintenance organization's proposed conversion to a for-profit organization.

282.19 (b) To fulfill the requirements under this section, the commissioner:

282.20 (1) may consult with the commissioners of human services and commerce;

282.21 (2) may enter into one or more contracts for professional or technical services;

282.22 (3) notwithstanding any law to the contrary, may use data submitted under Minnesota  
282.23 Statutes, sections 62U.04 and 144.695 to 144.705, and other data held by the commissioner  
282.24 for purposes of regulating health maintenance organizations or already submitted to the  
282.25 commissioner by health carriers; and

282.26 (4) may collect from health maintenance organizations and their parent or affiliated  
282.27 companies, financial data and other information, including nonpublic data and trade secret  
282.28 data, that are deemed necessary by the commissioner to conduct the study and develop the  
282.29 recommendations under this section. Health maintenance organizations must provide the  
282.30 commissioner with any information requested by the commissioner under this clause, in  
282.31 the form and manner specified by the commissioner. Any data collected by the commissioner  
282.32 under this clause is classified as confidential data as defined in Minnesota Statutes, section

283.1 13.02, subdivision 3 or protected nonpublic data as defined in Minnesota Statutes, section  
283.2 13.02, subdivision 13.

283.3 (c) No later than October 1, 2023, the commissioner must seek public comments on the  
283.4 regulation of conversion transactions involving nonprofit health maintenance organizations.

283.5 (d) The commissioner may use the enforcement authority in Minnesota Statutes, section  
283.6 62D.17, if a health maintenance organization fails to comply with a request for information  
283.7 under paragraph (b), clause (4).

283.8 (e) The commissioner shall submit preliminary findings from this study to the chairs of  
283.9 the legislative committees with jurisdiction over health and human services by January 15,  
283.10 2024, and shall submit a final report and recommendations to the legislature by June 30,  
283.11 2024.

283.12 Sec. 198. **STUDY OF THE DEVELOPMENT OF A STATEWIDE REGISTRY FOR**  
283.13 **PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT.**

283.14 Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have  
283.15 the meanings given.

283.16 (b) "Commissioner" means the commissioner of health.

283.17 (c) "Life-sustaining treatment" means any medical procedure, pharmaceutical drug,  
283.18 medical device, or medical intervention that maintains life by sustaining, restoring, or  
283.19 supplanting a vital function. Life-sustaining treatment does not include routine care necessary  
283.20 to sustain patient cleanliness and comfort.

283.21 (d) "POLST" means a provider order for life-sustaining treatment, signed by a physician,  
283.22 advanced practice registered nurse, or physician assistant, to ensure that the medical treatment  
283.23 preferences of a patient with an advanced serious illness who is nearing the end of the their  
283.24 life are honored.

283.25 (e) "POLST form" means a portable medical form used to communicate a physician's  
283.26 order to help ensure that a patient's medical treatment preferences are conveyed to emergency  
283.27 medical service personnel and other health care providers.

283.28 Subd. 2. **Establishment.** (a) The commissioner, in consultation with the advisory  
283.29 committee established in paragraph (c), shall develop recommendations for a statewide  
283.30 registry of POLST forms to ensure that a patient's medical treatment preferences are followed  
283.31 by all health care providers. The registry must allow for the submission of completed POLST

284.1 forms and for the forms to be accessed by health care providers and emergency medical  
284.2 service personnel in a timely manner for the provision of care or services.

284.3 (b) The commissioner shall develop recommendations on the following:

284.4 (1) electronic capture, storage, and security of information in the registry;

284.5 (2) procedures to protect the accuracy and confidentiality of information submitted to  
284.6 the registry;

284.7 (3) limits as to who can access the registry;

284.8 (4) where the registry should be housed;

284.9 (5) ongoing funding models for the registry; and

284.10 (6) any other action needed to ensure that patients' rights are protected and that their  
284.11 health care decisions are followed.

284.12 (c) The commissioner shall create an advisory committee with members representing  
284.13 physicians, physician assistants, advanced practice registered nurses, nursing homes,  
284.14 emergency medical system providers, hospice and palliative care providers, the disability  
284.15 community, attorneys, medical ethicists, and the religious community.

284.16 Subd. 3. **Report.** The commissioner shall submit recommendations on establishing a  
284.17 statewide registry of POLST forms to the chairs and ranking minority members of the  
284.18 legislative committees with jurisdiction over health and human services policy and finance  
284.19 by February 1, 2024, and implement the registry no later than December 1, 2024.

284.20 Sec. 199. **VACCINES FOR UNINSURED AND UNDERINSURED ADULTS.**

284.21 The commissioner of health shall administer a program to provide vaccines to uninsured  
284.22 and underinsured adults. The commissioner shall determine adult eligibility for free or  
284.23 low-cost vaccines under this program and shall enroll clinics to participate in the program  
284.24 and administer vaccines recommended by the Centers for Disease Control and Prevention.  
284.25 In administering the program, the commissioner shall address racial and ethnic disparities  
284.26 in vaccine coverage rates. State money appropriated for purposes of this section shall be  
284.27 used to supplement, but not supplant, available federal funding for purposes of this section.

284.28 Sec. 200. **WORKPLACE SAFETY GRANTS; HEALTH CARE ENTITIES AND**  
284.29 **HUMAN SERVICES PROVIDERS.**

284.30 Subdivision 1. **Grant program established.** The commissioner of health shall administer  
284.31 a program to award workplace safety grants to health care entities and human services

285.1 providers to increase safety measures at health care settings and at human services workplaces  
285.2 providing behavioral health care; services for children, families, and vulnerable adults;  
285.3 services for older adults and people with disabilities; and other social services or related  
285.4 care.

285.5 Subd. 2. **Eligible applicants; application.** (a) Entities eligible for a grant under this  
285.6 section shall include health systems, hospitals, medical clinics, dental clinics, ambulance  
285.7 services, community health clinics, county human services agencies, Tribal human services  
285.8 agencies, and other human services provider organizations.

285.9 (b) An entity seeking a grant under this section must submit an application to the  
285.10 commissioner in a form and manner prescribed by the commissioner. An application must  
285.11 include information about:

285.12 (1) the type of entity or organization seeking grant funding;

285.13 (2) the specific safety measures or activities for which the applicant will use the grant  
285.14 funding;

285.15 (3) the specific policies that will be implemented or upheld to ensure that individuals'  
285.16 rights to privacy and data protection are protected during the use of safety equipment obtained  
285.17 or operated through grant funding;

285.18 (4) a proposed budget for each of the specific activities for which the applicant will use  
285.19 the grant funding;

285.20 (5) an outline of efforts to enhance or improve existing safety measures or proposed  
285.21 new measures to improve the safety of staff at the entity, agency, or organization;

285.22 (6) sample consent forms for any safety equipment that has capacity to record, store, or  
285.23 share audio or video that will be collected from patients or clients prior to implementation  
285.24 of grant-funded safety measures, excluding equipment located in public spaces in  
285.25 provider-controlled, licensed settings;

285.26 (7) how the grant-funded measures will lead to long-term improvements in safety and  
285.27 stability for staff and for patients and clients accessing health care or services from the  
285.28 applicant; and

285.29 (8) methods the applicant will use to evaluate effectiveness of the safety measures and  
285.30 changes that will be made if the measures are deemed ineffective.

285.31 Subd. 3. **Grant awards.** Grants must be awarded to eligible applicants that meet  
285.32 application requirements on a first-come, first-served basis. Forty percent of grant funds

286.1 must be awarded to eligible applicants located outside of the seven-county metropolitan  
286.2 area. Each grant award must be for at least \$5,000, but no more than \$100,000.

286.3 Subd. 4. Allowable uses of grant funds. (a) Grant funds may be used for one or more  
286.4 of the following:

286.5 (1) the procurement and installation of safety equipment, including but not limited to  
286.6 cellular telephones; personal radios; wearable tracking devices for staff to share their location  
286.7 with supervisors, subject to the federal Health Insurance Portability and Accountability Act  
286.8 of 1996 (HIPAA) data privacy requirements outlined in Code of Federal Regulations, title  
286.9 45, parts 160 and 164, subparts A and E; security systems and cameras in public spaces of  
286.10 provider-controlled, licensed settings or of health care settings; and panic buttons;

286.11 (2) training for staff, which may include:

286.12 (i) sessions and exercises for crisis management, strategies for de-escalating conflict  
286.13 situations, safety planning, and self-defense in accordance with positive support strategies  
286.14 under Minnesota Rules, chapter 9544, and person-centered planning and service delivery  
286.15 according to Minnesota Statutes, section 245D.07, subdivision 1a;

286.16 (ii) training in culturally informed and culturally affirming practices, including linguistic  
286.17 training;

286.18 (iii) training in trauma-informed social, emotional, and behavioral support; and

286.19 (iv) other training topics, sessions, and exercises the commissioner determines to be  
286.20 appropriate;

286.21 (3) facility safety improvements, including but not limited to a threat and vulnerability  
286.22 review and barrier protection;

286.23 (4) support services, counseling, and additional resources for staff who have experienced  
286.24 safety concerns or trauma-related incidents in the workplace;

286.25 (5) installation and implementation of an internal data incident tracking system to track  
286.26 and prevent workplace safety incidents; and

286.27 (6) other prevention and mitigation measures and safety training, resources, and support  
286.28 services the commissioner determines to be appropriate.

286.29 (b) The following restrictions apply to the eligible uses of grant funds under paragraph  
286.30 (a):

286.31 (1) safety equipment must not include:

- 287.1 (i) tools or devices that facilitate physical or chemical restraint;
- 287.2 (ii) barriers, environmental modifications, or other tools or devices that facilitate
- 287.3 individual seclusion, except plexiglass barriers in office settings are allowed;
- 287.4 (iii) wearable body cameras; or
- 287.5 (iv) wearable tracking devices that have the capacity to store location data;
- 287.6 (2) security cameras must only be used in staff spaces and entry points of buildings and
- 287.7 may not be used in common areas, bedrooms, and bathrooms;
- 287.8 (3) in settings that are required to comply with the positive supports rule, all safety
- 287.9 equipment or measures must comply with Minnesota Rules, chapter 9544;
- 287.10 (4) settings licensed under Minnesota Statutes, section 245D, must follow person-centered
- 287.11 practices according to Minnesota Statutes, section 245D.07;
- 287.12 (5) any safety equipment purchased with grant funding that has electronic monitoring
- 287.13 capacity must be used according to Minnesota Statutes, section 144.6502, or the brain injury,
- 287.14 community alternative care, community access for disability inclusion, and developmental
- 287.15 disabilities federal waiver plan language that outlines monitoring technology use;
- 287.16 (6) prior to the use of safety equipment that has capacity to record, store, and share audio,
- 287.17 video, or a combination thereof, the grant recipient must:
- 287.18 (i) provide patients or clients with information about electronic monitoring in a way that
- 287.19 is most accessible to the patients or clients, including the definition of electronic monitoring,
- 287.20 the type of device that will be in use, how the footage captured will be used, with whom
- 287.21 the footage captured will be shared, and a statement that a patient or client has the right to
- 287.22 decline use of safety equipment that has capacity to record, store, and share audio, video,
- 287.23 or a combination thereof;
- 287.24 (ii) provide notice every time electronic monitoring devices are in use; and
- 287.25 (iii) obtain written consent from anyone whose audio or video may be recorded during
- 287.26 the time the device is in use and, if applicable, from guardians of individuals whose audio
- 287.27 or video may be recorded during the time the device is in use; and
- 287.28 (7) in settings that provide home and community-based services, if at any point a client
- 287.29 or their guardian declines the use of safety equipment that has capacity to record, store, or
- 287.30 share audio, video, or a combination thereof or revokes prior consent to such use, the provider
- 287.31 must cease using the safety equipment immediately and indefinitely. A provider may not
- 287.32 deny or delay the provision of services as a result of an individual's decision to decline the

288.1 use of safety equipment that has capacity to record, store, or share audio, video, or a  
288.2 combination thereof.

288.3 (c) All video, audio, or other personally identifiable information collected through safety  
288.4 equipment paid for by grant funds under this section must:

288.5 (1) be treated consistently with the federal Health Insurance Portability and Accountability  
288.6 Act of 1996 (HIPAA) requirements outlined in Code of Federal Regulations, title 45, parts  
288.7 160 and 164, subparts A and E;

288.8 (2) be subject to applicable rules of evidence and procedure if admitted into evidence  
288.9 in a civil, criminal, or administrative proceeding; and

288.10 (3) not result in the denial or delay of services provided to an individual.

288.11 Subd. 5. **Report.** Within two years after receiving grant funds under this section, each  
288.12 grant recipient must submit a report to the commissioner. The commissioner must submit  
288.13 a compilation of the reports to the chairs and ranking minority members of the legislative  
288.14 committees with jurisdiction over health and human services, the Office of Ombudsman  
288.15 for Long-Term Care, and Office of Ombudsman for Mental Health and Developmental  
288.16 Disabilities. Grant recipient reports to the commissioner must include:

288.17 (1) the number of workplace safety incidents that occurred over the course of the grant  
288.18 period;

288.19 (2) the number and type of safety measures funded by the grants, and how those safety  
288.20 measures helped alleviate or de-escalate workplace safety incidents;

288.21 (3) the number of staff benefiting from safety measures implemented through grant  
288.22 funding;

288.23 (4) the number of patients or clients benefiting from safety measures implemented  
288.24 through grant funding;

288.25 (5) practices implemented concurrently with the use of safety equipment that ensured  
288.26 that the rights of patients or clients served were upheld;

288.27 (6) the number of patients or clients who declined to consent to the use of any safety  
288.28 equipment that had capacity to record, store, or share audio, video, or a combination thereof;

288.29 (7) an evaluation of the effectiveness of the safety measures, including assessment of  
288.30 whether and how the grant funding has led or will lead to improved safety and service  
288.31 provisions for staff, patients, and clients; and

289.1 (8) changes to policy or practice that were made if safety measures implemented using  
289.2 grant funds were deemed ineffective.

289.3 Subd. 6. **Technical assistance.** The commissioner must provide technical assistance to  
289.4 grant applicants throughout the application process and to applicants and grant recipients  
289.5 regarding grant distribution and required grant recipient reporting

289.6 Sec. 201. **TASK FORCE ON PREGNANCY HEALTH AND SUBSTANCE USE**  
289.7 **DISORDERS.**

289.8 Subdivision 1. **Establishment.** The Task Force on Pregnancy Health and Substance Use  
289.9 Disorders is established to recommend protocols for when physicians, advanced practice  
289.10 registered nurses, and physician assistants should administer a toxicology test and  
289.11 requirements for reporting for prenatal exposure to a controlled substance.

289.12 Subd. 2. **Membership.** (a) The task force shall consist of the following members:

289.13 (1) a physician licensed in Minnesota to practice obstetrics and gynecology who provides  
289.14 care primarily to medical assistance enrollees during pregnancy appointed by the American  
289.15 College of Obstetricians and Gynecologists;

289.16 (2) a physician licensed in Minnesota to practice pediatrics or family medicine who  
289.17 provides care primarily to medical assistance enrollees with substance use disorders or who  
289.18 provides addiction medicine care during pregnancy appointed by the Minnesota Medical  
289.19 Association;

289.20 (3) a certified nurse-midwife licensed as an advanced practice registered nurse in  
289.21 Minnesota who provides care primarily to medical assistance enrollees with substance use  
289.22 disorders or provides addiction medicine care during pregnancy appointed by the Minnesota  
289.23 Advanced Practice Registered Nurses Coalition;

289.24 (4) two representatives of county social services agencies, one from a county outside  
289.25 the seven-county metropolitan area and one from a county within the seven-county  
289.26 metropolitan area, appointed by the Minnesota Association of County Social Service  
289.27 Administrators;

289.28 (5) one representative from the Board of Social Work;

289.29 (6) two Tribal representatives appointed by the Minnesota Indian Affairs Council;

289.30 (7) two members who identify as Black or African American and who have lived  
289.31 experience with the child welfare system and substance use disorders appointed by the  
289.32 Cultural and Ethnic Communities Leadership Council;

290.1 (8) two members who are licensed substance use disorder treatment providers appointed  
290.2 by the Minnesota Association of Resources for Recovery and Chemical Health;

290.3 (9) one member representing hospitals appointed by the Minnesota Hospital Association;

290.4 (10) one designee of the commissioner of health with expertise in substance use disorders  
290.5 and treatment;

290.6 (11) two members who identify as Native American or American Indian and who have  
290.7 lived experience with the child welfare system and substance use disorders appointed by  
290.8 the Minnesota Indian Affairs Council;

290.9 (12) two members from the Council for Minnesotans of African Heritage; and

290.10 (13) one member of the Minnesota Perinatal Quality Collaborative.

290.11 (b) Appointments to the task force must be made by October 1, 2023.

290.12 Subd. 3. **Chairs; meetings.** (a) The task force shall elect a chair and cochair at the first  
290.13 meeting, which shall be convened no later than October 15, 2023.

290.14 (b) Task force meetings are subject to the Minnesota Open Meeting Law under Minnesota  
290.15 Statutes, chapter 13D.

290.16 Subd. 4. **Administrative support.** The Department of Health must provide administrative  
290.17 support and meeting space for the task force.

290.18 Subd. 5. **Duties; reports.** (a) The task force shall develop recommended protocols for  
290.19 when a toxicology test for prenatal exposure to a controlled substance should be administered  
290.20 to a birthing parent and a newborn infant. The task force must also recommend protocols  
290.21 for providing notice or reporting of prenatal exposure to a controlled substance to local  
290.22 welfare agencies under Minnesota Statutes, chapter 260E.

290.23 (b) No later than December 1, 2024, the task force must submit a written report to the  
290.24 chairs and ranking minority members of the legislative committees and divisions with  
290.25 jurisdiction over health and human services on the task force's activities and recommendations  
290.26 on the protocols developed under paragraph (a).

290.27 Subd. 6. **Expiration.** The task force shall expire upon submission of the report required  
290.28 under subdivision 5, paragraph (b), or December 1, 2024, whichever is later.

291.1 Sec. 202. **REVISOR INSTRUCTION.**

291.2 (a) The revisor of statutes shall change the term "cancer surveillance system" to "cancer  
291.3 reporting system" wherever it appears in the next edition of Minnesota Statutes and Minnesota  
291.4 Rules and in the online publication.

291.5 (b) The revisor of statutes shall amend the headnote for Minnesota Statutes, section  
291.6 145.423, to read "RECOGNITION OF INFANT WHO IS BORN ALIVE."

291.7 (c) In Minnesota Statutes, section 144.7055, the revisor shall renumber paragraphs (b)  
291.8 to (e) alphabetically as individual subdivisions under Minnesota Statutes, section 144.7051.  
291.9 The revisor shall make any necessary changes to sentence structure for this renumbering  
291.10 while preserving the meaning of the text. The revisor shall also make necessary  
291.11 cross-reference changes in Minnesota Statutes and Minnesota Rules consistent with the  
291.12 renumbering.

291.13 Sec. 203. **REPEALER.**

291.14 (a) Minnesota Rules, parts 4640.1500; 4640.1600; 4640.1700; 4640.1800; 4640.1900;  
291.15 4640.2000; 4640.2100; 4640.2200; 4640.2300; 4640.2400; 4640.2500; 4640.2600;  
291.16 4640.2700; 4640.2800; 4640.2900; 4640.3000; 4640.3100; 4640.3200; 4640.3300;  
291.17 4640.3400; 4640.3500; 4640.3600; 4640.3700; 4640.3800; 4640.3900; 4640.4000;  
291.18 4640.4100; 4640.4200; 4640.4300; 4640.6100; 4640.6200; 4640.6300; 4640.6400;  
291.19 4645.0300; 4645.0400; 4645.0500; 4645.0600; 4645.0700; 4645.0800; 4645.0900;  
291.20 4645.1000; 4645.1100; 4645.1200; 4645.1300; 4645.1400; 4645.1500; 4645.1600;  
291.21 4645.1700; 4645.1800; 4645.1900; 4645.2000; 4645.2100; 4645.2200; 4645.2300;  
291.22 4645.2400; 4645.2500; 4645.2600; 4645.2700; 4645.2800; 4645.2900; 4645.3000;  
291.23 4645.3100; 4645.3200; 4645.3300; 4645.3400; 4645.3500; 4645.3600; 4645.3700;  
291.24 4645.3800; 4645.3805; 4645.3900; 4645.4000; 4645.4100; 4645.4200; 4645.4300;  
291.25 4645.4400; 4645.4500; 4645.4600; 4645.4700; 4645.4800; 4645.4900; 4645.5100; and  
291.26 4645.5200, are repealed effective January 1, 2024.

291.27 (b) Minnesota Statutes 2022, sections 62J.84, subdivision 5; 62U.10, subdivisions 6, 7,  
291.28 and 8; 144.059, subdivision 10; 144.9505, subdivision 3; 145.4235; and 153A.14, subdivision  
291.29 5, are repealed.

291.30 (c) Minnesota Rules, part 4615.3600, is repealed effective the day following final  
291.31 enactment.

291.32 (d) Minnesota Rules, parts 4700.1900; 4700.2000; 4700.2100; 4700.2210; 4700.2300,  
291.33 subparts 1, 3, 4, 4a, and 5; 4700.2410; 4700.2420; and 4700.2500, are repealed.

292.1 (e) Minnesota Statutes 2022, sections 62Q.145; 145.1621; 145.411, subdivisions 2 and  
292.2 4; 145.412; 145.413, subdivisions 2 and 3; 145.4131; 145.4132; 145.4133; 145.4134;  
292.3 145.4135; 145.4136; 145.415; 145.416; 145.423, subdivisions 2, 3, 4, 5, 6, 7, 8, and 9;  
292.4 145.4241; 145.4242; 145.4243; 145.4244; 145.4245; 145.4246; 145.4247; 145.4248;  
292.5 145.4249; 256B.011; 256B.40; 261.28; and 393.07, subdivision 11, are repealed effective  
292.6 the day following final enactment.

## 292.7 ARTICLE 4

### 292.8 MEDICAL EDUCATION AND RESEARCH COSTS

292.9 Section 1. Minnesota Statutes 2022, section 62J.692, subdivision 1, is amended to read:

292.10 Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions  
292.11 apply:

292.12 (b) "Accredited clinical training" means the clinical training provided by a medical  
292.13 education program that is accredited through an organization recognized by the Department  
292.14 of Education, the Centers for Medicare and Medicaid Services, or another national body  
292.15 who reviews the accrediting organizations for multiple disciplines and whose standards for  
292.16 recognizing accrediting organizations are reviewed and approved by the commissioner of  
292.17 health.

292.18 (c) "Commissioner" means the commissioner of health.

292.19 (d) "Clinical medical education program" means the accredited clinical training of  
292.20 physicians (medical students and residents), doctor of pharmacy practitioners (pharmacy  
292.21 students and residents), doctors of chiropractic, dentists (dental students and residents),  
292.22 advanced practice registered nurses (clinical nurse specialists, certified registered nurse  
292.23 anesthetists, nurse practitioners, and certified nurse midwives), physician assistants, dental  
292.24 therapists and advanced dental therapists, psychologists, clinical social workers, community  
292.25 paramedics, and community health workers.

292.26 (e) "Sponsoring institution" means a hospital, school, or consortium located in Minnesota  
292.27 that sponsors and maintains primary organizational and financial responsibility for a clinical  
292.28 medical education program in Minnesota and which is accountable to the accrediting body.

292.29 (f) "Teaching institution" means a hospital, medical center, clinic, or other organization  
292.30 that conducts a clinical medical education program in Minnesota.

292.31 (g) "Trainee" means a student or resident involved in a clinical medical education  
292.32 program.

293.1 (h) "Eligible trainee FTE's" means the number of trainees, as measured by full-time  
293.2 equivalent counts, that are at training sites located in Minnesota with currently active medical  
293.3 assistance enrollment status and a National Provider Identification (NPI) number where  
293.4 training occurs in either an inpatient or ambulatory patient care setting and where the training  
293.5 is funded, in part, by patient care revenues. Training that occurs in nursing facility settings  
293.6 is not eligible for funding under this section.

293.7 Sec. 2. Minnesota Statutes 2022, section 62J.692, subdivision 3, is amended to read:

293.8 Subd. 3. **Application process.** (a) A clinical medical education program conducted in  
293.9 Minnesota by a teaching institution to train physicians, doctor of pharmacy practitioners,  
293.10 dentists, chiropractors, physician assistants, dental therapists and advanced dental therapists,  
293.11 psychologists, clinical social workers, community paramedics, or community health workers  
293.12 is eligible for funds under subdivision 4 if the program:

293.13 (1) is funded, in part, by patient care revenues;

293.14 (2) occurs in patient care settings that face increased financial pressure as a result of  
293.15 competition with nonteaching patient care entities; and

293.16 (3) emphasizes primary care or specialties that are in undersupply in Minnesota.

293.17 (b) A clinical medical education program for advanced practice nursing is eligible for  
293.18 funds under subdivision 4 if the program meets the eligibility requirements in paragraph  
293.19 (a), clauses (1) to (3), and is sponsored by the University of Minnesota Academic Health  
293.20 Center, the Mayo Foundation, or institutions that are part of the Minnesota State Colleges  
293.21 and Universities system or members of the Minnesota Private College Council.

293.22 (c) Applications must be submitted to the commissioner by a sponsoring institution on  
293.23 behalf of an eligible clinical medical education program ~~and must be received by October~~  
293.24 ~~31 of each year for distribution in the following year~~ on a timeline determined by the  
293.25 commissioner. An application for funds must contain the following information: information  
293.26 the commissioner deems necessary to determine program eligibility based on the criteria  
293.27 in paragraphs (a) and (b) and to ensure the equitable distribution of funds.

293.28 ~~(1) the official name and address of the sponsoring institution and the official name and~~  
293.29 ~~site address of the clinical medical education programs on whose behalf the sponsoring~~  
293.30 ~~institution is applying;~~

293.31 ~~(2) the name, title, and business address of those persons responsible for administering~~  
293.32 ~~the funds;~~

294.1 ~~(3) for each clinical medical education program for which funds are being sought; the~~  
294.2 ~~type and specialty orientation of trainees in the program; the name, site address, and medical~~  
294.3 ~~assistance provider number and national provider identification number of each training~~  
294.4 ~~site used in the program; the federal tax identification number of each training site used in~~  
294.5 ~~the program, where available; the total number of trainees at each training site; and the total~~  
294.6 ~~number of eligible trainee FTEs at each site; and~~

294.7 ~~(4) other supporting information the commissioner deems necessary to determine program~~  
294.8 ~~eligibility based on the criteria in paragraphs (a) and (b) and to ensure the equitable~~  
294.9 ~~distribution of funds.~~

294.10 ~~(d) An application must include the information specified in clauses (1) to (3) for each~~  
294.11 ~~clinical medical education program on an annual basis for three consecutive years. After~~  
294.12 ~~that time, an application must include the information specified in clauses (1) to (3) when~~  
294.13 ~~requested, at the discretion of the commissioner:~~

294.14 ~~(1) audited clinical training costs per trainee for each clinical medical education program~~  
294.15 ~~when available or estimates of clinical training costs based on audited financial data;~~

294.16 ~~(2) a description of current sources of funding for clinical medical education costs,~~  
294.17 ~~including a description and dollar amount of all state and federal financial support, including~~  
294.18 ~~Medicare direct and indirect payments; and~~

294.19 ~~(3) other revenue received for the purposes of clinical training.~~

294.20 ~~(e)~~ (d) An applicant that does not provide information requested by the commissioner  
294.21 shall not be eligible for funds for the ~~current~~ applicable funding cycle.

294.22 Sec. 3. Minnesota Statutes 2022, section 62J.692, subdivision 4, is amended to read:

294.23 Subd. 4. **Distribution of funds.** (a) The commissioner shall annually distribute ~~the~~  
294.24 ~~available medical education funds~~ revenue credited or money transferred to the medical  
294.25 education and research costs account under subdivision 8 and section 297F.10, subdivision  
294.26 1, clause (2), to all qualifying applicants based on a public program volume factor, which  
294.27 is determined by the total volume of public program revenue received by each training site  
294.28 as a percentage of all public program revenue received by all training sites in the fund pool.

294.29 Public program revenue for the distribution formula includes revenue from medical  
294.30 assistance and prepaid medical assistance. Training sites that receive no public program  
294.31 revenue are ineligible for funds available under this subdivision. ~~For purposes of determining~~  
294.32 ~~training site level grants to be distributed under this paragraph, total statewide average costs~~  
294.33 ~~per trainee for medical residents is based on audited clinical training costs per trainee in~~

295.1 ~~primary care clinical medical education programs for medical residents. Total statewide~~  
295.2 ~~average costs per trainee for dental residents is based on audited clinical training costs per~~  
295.3 ~~trainee in clinical medical education programs for dental students. Total statewide average~~  
295.4 ~~costs per trainee for pharmacy residents is based on audited clinical training costs per trainee~~  
295.5 ~~in clinical medical education programs for pharmacy students.~~

295.6 Training sites whose training site level grant is less than \$5,000, based on the ~~formula~~  
295.7 formulas described in this ~~paragraph~~ subdivision, or that train fewer than 0.1 FTE eligible  
295.8 trainees, are ineligible for funds available under this subdivision. No training sites shall  
295.9 receive a grant per FTE trainee that is in excess of the 95th percentile grant per FTE across  
295.10 all eligible training sites; grants in excess of this amount will be redistributed to other eligible  
295.11 sites based on the ~~formula~~ formulas described in this ~~paragraph~~ subdivision.

295.12 ~~(b) For funds distributed in fiscal years 2014 and 2015, the distribution formula shall~~  
295.13 ~~include a supplemental public program volume factor, which is determined by providing a~~  
295.14 ~~supplemental payment to training sites whose public program revenue accounted for at least~~  
295.15 ~~0.98 percent of the total public program revenue received by all eligible training sites. The~~  
295.16 ~~supplemental public program volume factor shall be equal to ten percent of each training~~  
295.17 ~~site's grant for funds distributed in fiscal year 2014 and for funds distributed in fiscal year~~  
295.18 ~~2015. Grants to training sites whose public program revenue accounted for less than 0.98~~  
295.19 ~~percent of the total public program revenue received by all eligible training sites shall be~~  
295.20 ~~reduced by an amount equal to the total value of the supplemental payment. For fiscal year~~  
295.21 ~~2016 and beyond, the distribution of funds shall be based solely on the public program~~  
295.22 ~~volume factor as described in paragraph (a). Money appropriated through the state general~~  
295.23 ~~fund, the health care access fund, and any additional fund for the purpose of funding medical~~  
295.24 ~~education and research costs and that does not require federal approval must be awarded~~  
295.25 ~~only to eligible training sites that do not qualify for a medical education and research cost~~  
295.26 ~~rate factor under sections 256.969, subdivision 2b, paragraph (k), or 256B.75, paragraph~~  
295.27 ~~(b). The commissioner shall distribute the available medical education money appropriated~~  
295.28 ~~to eligible training sites that do not qualify for a medical education and research cost rate~~  
295.29 ~~factor based on a distribution formula determined by the commissioner. The distribution~~  
295.30 ~~formula under this paragraph must consider clinical training costs, public program revenues,~~  
295.31 ~~and other factors identified by the commissioner that address the objective of supporting~~  
295.32 ~~clinical training.~~

295.33 (c) Funds distributed shall not be used to displace current funding appropriations from  
295.34 federal or state sources.

296.1 (d) Funds shall be distributed to the sponsoring institutions indicating the amount to be  
296.2 distributed to each of the sponsor's clinical medical education programs based on the criteria  
296.3 in this subdivision and in accordance with the commissioner's approval letter. Each clinical  
296.4 medical education program must distribute funds allocated under paragraphs (a) and (b) to  
296.5 the training sites as specified in the commissioner's approval letter. Sponsoring institutions,  
296.6 which are accredited through an organization recognized by the Department of Education  
296.7 or the Centers for Medicare and Medicaid Services, may contract directly with training sites  
296.8 to provide clinical training. To ensure the quality of clinical training, those accredited  
296.9 sponsoring institutions must:

296.10 (1) develop contracts specifying the terms, expectations, and outcomes of the clinical  
296.11 training conducted at sites; and

296.12 (2) take necessary action if the contract requirements are not met. Action may include  
296.13 ~~the withholding of payments~~ disqualifying the training site under this section or the removal  
296.14 of students from the site.

296.15 (e) Use of funds is limited to expenses related to eligible clinical training ~~program~~ costs  
296.16 ~~for eligible programs.~~ The commissioner shall develop a methodology for determining  
296.17 eligible costs.

296.18 (f) Any funds ~~not~~ that cannot be distributed in accordance with the commissioner's  
296.19 approval letter must be returned to the medical education and research fund within 30 days  
296.20 of receiving notice from the commissioner. ~~The commissioner shall distribute returned~~  
296.21 ~~funds to the appropriate training sites in accordance with the commissioner's approval letter.~~  
296.22 When appropriate, the commissioner shall include the undistributed money in the subsequent  
296.23 distribution cycle using the applicable methodology described in this subdivision.

296.24 ~~(g) A maximum of \$150,000 of the funds dedicated to the commissioner under section~~  
296.25 ~~297F.10, subdivision 1, clause (2), may be used by the commissioner for administrative~~  
296.26 ~~expenses associated with implementing this section.~~

296.27 Sec. 4. Minnesota Statutes 2022, section 62J.692, subdivision 5, is amended to read:

296.28 Subd. 5. **Report.** (a) Sponsoring institutions receiving funds under this section must  
296.29 ~~sign and~~ submit a medical education grant verification report (GVR) to verify that the correct  
296.30 grant amount was forwarded to each eligible training site. ~~If the sponsoring institution fails~~  
296.31 ~~to submit the GVR by the stated deadline, or to request and meet the deadline for an~~  
296.32 ~~extension, the sponsoring institution is required to return the full amount of funds received~~  
296.33 ~~to the commissioner within 30 days of receiving notice from the commissioner. The~~

297.1 ~~commissioner shall distribute returned funds to the appropriate training sites in accordance~~  
 297.2 ~~with the commissioner's approval letter.~~

297.3 (b) The reports must provide verification of the distribution of the funds and must include:

297.4 ~~(1) the total number of eligible trainee FTEs in each clinical medical education program;~~

297.5 ~~(2) the name of each funded program and, for each program, the dollar amount distributed~~  
 297.6 ~~to each training site and a training site expenditure report;~~

297.7 ~~(3) (1)~~ documentation of any discrepancies between the ~~initial~~ grant distribution notice  
 297.8 included in the commissioner's approval letter and the actual distribution;

297.9 ~~(4) (2)~~ a statement by the sponsoring institution stating that the completed grant  
 297.10 verification report is valid and accurate; and

297.11 ~~(5) (3)~~ other information the commissioner deems appropriate to evaluate the effectiveness  
 297.12 of the use of funds for medical education.

297.13 ~~(e) Each year, the commissioner shall provide an annual summary report to the legislature~~  
 297.14 ~~on the implementation of this section. This report is exempt from section 144.05, subdivision~~  
 297.15 ~~7.~~

297.16 Sec. 5. Minnesota Statutes 2022, section 62J.692, subdivision 8, is amended to read:

297.17 Subd. 8. **Federal financial participation.** The commissioner of human services shall  
 297.18 seek to maximize federal financial participation in payments for the dedicated revenue for  
 297.19 medical education and research costs provided under section 297F.10, subdivision 1, clause  
 297.20 (2).

297.21 ~~The commissioner shall use physician clinic rates where possible to maximize federal~~  
 297.22 ~~financial participation. Any additional funds that become available must be distributed under~~  
 297.23 ~~subdivision 4, paragraph (a).~~

297.24 Sec. 6. [144.1913] CLINICAL DENTAL EDUCATION INNOVATION GRANTS.

297.25 (a) The commissioner shall award clinical dental education innovation grants to teaching  
 297.26 institutions and clinical training sites for projects that increase dental access for underserved  
 297.27 populations and promote innovative clinical training of dental professionals. In awarding  
 297.28 the grants, the commissioner shall consider the following:

297.29 (1) potential to successfully increase access to dental services for an underserved  
 297.30 population;

- 298.1 (2) the long-term viability of the project to improve access to dental services beyond  
298.2 the period of initial funding;
- 298.3 (3) evidence of collaboration between the applicant and local communities;
- 298.4 (4) efficiency in the use of grant funding; and
- 298.5 (5) the priority level of the project in relation to state education, access, and workforce  
298.6 goals.
- 298.7 (b) The commissioner shall periodically evaluate the priorities in awarding innovations  
298.8 grants under this section to ensure that the priorities meet the changing workforce needs of  
298.9 the state.

298.10 Sec. 7. Minnesota Statutes 2022, section 256.969, subdivision 2b, is amended to read:

298.11 Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November  
298.12 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according  
298.13 to the following:

298.14 (1) critical access hospitals as defined by Medicare shall be paid using a cost-based  
298.15 methodology;

298.16 (2) long-term hospitals as defined by Medicare shall be paid on a per diem methodology  
298.17 under subdivision 25;

298.18 (3) rehabilitation hospitals or units of hospitals that are recognized as rehabilitation  
298.19 distinct parts as defined by Medicare shall be paid according to the methodology under  
298.20 subdivision 12; and

298.21 (4) all other hospitals shall be paid on a diagnosis-related group (DRG) methodology.

298.22 (b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not  
298.23 be rebased, except that a Minnesota long-term hospital shall be rebased effective January  
298.24 1, 2011, based on its most recent Medicare cost report ending on or before September 1,  
298.25 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on  
298.26 December 31, 2010. For rate setting periods after November 1, 2014, in which the base  
298.27 years are updated, a Minnesota long-term hospital's base year shall remain within the same  
298.28 period as other hospitals.

298.29 (c) Effective for discharges occurring on and after November 1, 2014, payment rates  
298.30 for hospital inpatient services provided by hospitals located in Minnesota or the local trade  
298.31 area, except for the hospitals paid under the methodologies described in paragraph (a),  
298.32 clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a

299.1 manner similar to Medicare. The base year or years for the rates effective November 1,  
299.2 2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral,  
299.3 ensuring that the total aggregate payments under the rebased system are equal to the total  
299.4 aggregate payments that were made for the same number and types of services in the base  
299.5 year. Separate budget neutrality calculations shall be determined for payments made to  
299.6 critical access hospitals and payments made to hospitals paid under the DRG system. Only  
299.7 the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being  
299.8 rebased during the entire base period shall be incorporated into the budget neutrality  
299.9 calculation.

299.10 (d) For discharges occurring on or after November 1, 2014, through the next rebasing  
299.11 that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph  
299.12 (a), clause (4), shall include adjustments to the projected rates that result in no greater than  
299.13 a five percent increase or decrease from the base year payments for any hospital. Any  
299.14 adjustments to the rates made by the commissioner under this paragraph and paragraph (e)  
299.15 shall maintain budget neutrality as described in paragraph (c).

299.16 (e) For discharges occurring on or after November 1, 2014, the commissioner may make  
299.17 additional adjustments to the rebased rates, and when evaluating whether additional  
299.18 adjustments should be made, the commissioner shall consider the impact of the rates on the  
299.19 following:

299.20 (1) pediatric services;

299.21 (2) behavioral health services;

299.22 (3) trauma services as defined by the National Uniform Billing Committee;

299.23 (4) transplant services;

299.24 (5) obstetric services, newborn services, and behavioral health services provided by  
299.25 hospitals outside the seven-county metropolitan area;

299.26 (6) outlier admissions;

299.27 (7) low-volume providers; and

299.28 (8) services provided by small rural hospitals that are not critical access hospitals.

299.29 (f) Hospital payment rates established under paragraph (c) must incorporate the following:

299.30 (1) for hospitals paid under the DRG methodology, the base year payment rate per  
299.31 admission is standardized by the applicable Medicare wage index and adjusted by the  
299.32 hospital's disproportionate population adjustment;

300.1 (2) for critical access hospitals, payment rates for discharges between November 1, 2014,  
300.2 and June 30, 2015, shall be set to the same rate of payment that applied for discharges on  
300.3 October 31, 2014;

300.4 (3) the cost and charge data used to establish hospital payment rates must only reflect  
300.5 inpatient services covered by medical assistance; and

300.6 (4) in determining hospital payment rates for discharges occurring on or after the rate  
300.7 year beginning January 1, 2011, through December 31, 2012, the hospital payment rate per  
300.8 discharge shall be based on the cost-finding methods and allowable costs of the Medicare  
300.9 program in effect during the base year or years. In determining hospital payment rates for  
300.10 discharges in subsequent base years, the per discharge rates shall be based on the cost-finding  
300.11 methods and allowable costs of the Medicare program in effect during the base year or  
300.12 years.

300.13 (g) The commissioner shall validate the rates effective November 1, 2014, by applying  
300.14 the rates established under paragraph (c), and any adjustments made to the rates under  
300.15 paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the  
300.16 total aggregate payments for the same number and types of services under the rebased rates  
300.17 are equal to the total aggregate payments made during calendar year 2013.

300.18 (h) Effective for discharges occurring on or after July 1, 2017, and every two years  
300.19 thereafter, payment rates under this section shall be rebased to reflect only those changes  
300.20 in hospital costs between the existing base year or years and the next base year or years. In  
300.21 any year that inpatient claims volume falls below the threshold required to ensure a  
300.22 statistically valid sample of claims, the commissioner may combine claims data from two  
300.23 consecutive years to serve as the base year. Years in which inpatient claims volume is  
300.24 reduced or altered due to a pandemic or other public health emergency shall not be used as  
300.25 a base year or part of a base year if the base year includes more than one year. Changes in  
300.26 costs between base years shall be measured using the lower of the hospital cost index defined  
300.27 in subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per  
300.28 claim. The commissioner shall establish the base year for each rebasing period considering  
300.29 the most recent year or years for which filed Medicare cost reports are available. The  
300.30 estimated change in the average payment per hospital discharge resulting from a scheduled  
300.31 rebasing must be calculated and made available to the legislature by January 15 of each  
300.32 year in which rebasing is scheduled to occur, and must include by hospital the differential  
300.33 in payment rates compared to the individual hospital's costs.

301.1 (i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates  
301.2 for critical access hospitals located in Minnesota or the local trade area shall be determined  
301.3 using a new cost-based methodology. The commissioner shall establish within the  
301.4 methodology tiers of payment designed to promote efficiency and cost-effectiveness.  
301.5 Payment rates for hospitals under this paragraph shall be set at a level that does not exceed  
301.6 the total cost for critical access hospitals as reflected in base year cost reports. Until the  
301.7 next rebasing that occurs, the new methodology shall result in no greater than a five percent  
301.8 decrease from the base year payments for any hospital, except a hospital that had payments  
301.9 that were greater than 100 percent of the hospital's costs in the base year shall have their  
301.10 rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and  
301.11 after July 1, 2016, covered under this paragraph shall be increased by the inflation factor  
301.12 in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not  
301.13 be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the  
301.14 following criteria:

301.15 (1) hospitals that had payments at or below 80 percent of their costs in the base year  
301.16 shall have a rate set that equals 85 percent of their base year costs;

301.17 (2) hospitals that had payments that were above 80 percent, up to and including 90  
301.18 percent of their costs in the base year shall have a rate set that equals 95 percent of their  
301.19 base year costs; and

301.20 (3) hospitals that had payments that were above 90 percent of their costs in the base year  
301.21 shall have a rate set that equals 100 percent of their base year costs.

301.22 (j) The commissioner may refine the payment tiers and criteria for critical access hospitals  
301.23 to coincide with the next rebasing under paragraph (h). The factors used to develop the new  
301.24 methodology may include, but are not limited to:

301.25 (1) the ratio between the hospital's costs for treating medical assistance patients and the  
301.26 hospital's charges to the medical assistance program;

301.27 (2) the ratio between the hospital's costs for treating medical assistance patients and the  
301.28 hospital's payments received from the medical assistance program for the care of medical  
301.29 assistance patients;

301.30 (3) the ratio between the hospital's charges to the medical assistance program and the  
301.31 hospital's payments received from the medical assistance program for the care of medical  
301.32 assistance patients;

301.33 (4) the statewide average increases in the ratios identified in clauses (1), (2), and (3);

302.1 (5) the proportion of that hospital's costs that are administrative and trends in  
302.2 administrative costs; and

302.3 (6) geographic location.

302.4 (k) Effective for discharges occurring on or after January 1, 2024, the rates paid to  
302.5 hospitals described in paragraph (a), clauses (2) to (4), must include a rate factor specific  
302.6 to each hospital that qualifies for a medical education and research cost distribution under  
302.7 section 62J.692 subdivision 4, paragraph (a).

302.8 Sec. 8. Minnesota Statutes 2022, section 256B.75, is amended to read:

302.9 **256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.**

302.10 (a) For outpatient hospital facility fee payments for services rendered on or after October  
302.11 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge,  
302.12 or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for  
302.13 which there is a federal maximum allowable payment. Effective for services rendered on  
302.14 or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and  
302.15 emergency room facility fees shall be increased by eight percent over the rates in effect on  
302.16 December 31, 1999, except for those services for which there is a federal maximum allowable  
302.17 payment. Services for which there is a federal maximum allowable payment shall be paid  
302.18 at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total  
302.19 aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare  
302.20 upper limit. If it is determined that a provision of this section conflicts with existing or  
302.21 future requirements of the United States government with respect to federal financial  
302.22 participation in medical assistance, the federal requirements prevail. The commissioner  
302.23 may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial  
302.24 participation resulting from rates that are in excess of the Medicare upper limitations.

302.25 (b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory  
302.26 surgery hospital facility fee services for critical access hospitals designated under section  
302.27 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the  
302.28 cost-finding methods and allowable costs of the Medicare program. Effective for services  
302.29 provided on or after July 1, 2015, rates established for critical access hospitals under this  
302.30 paragraph for the applicable payment year shall be the final payment and shall not be settled  
302.31 to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal  
302.32 year ending in 2017, the rate for outpatient hospital services shall be computed using  
302.33 information from each hospital's Medicare cost report as filed with Medicare for the year  
302.34 that is two years before the year that the rate is being computed. Rates shall be computed

303.1 using information from Worksheet C series until the department finalizes the medical  
303.2 assistance cost reporting process for critical access hospitals. After the cost reporting process  
303.3 is finalized, rates shall be computed using information from Title XIX Worksheet D series.  
303.4 The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs  
303.5 related to rural health clinics and federally qualified health clinics, divided by ancillary  
303.6 charges plus outpatient charges, excluding charges related to rural health clinics and federally  
303.7 qualified health clinics. Effective for services delivered on or after January 1, 2024, the  
303.8 rates paid to critical access hospitals under this section must be adjusted to include the  
303.9 amount of any distributions under section 62J.692, subdivision 4, paragraph (a), that were  
303.10 not included in the rate adjustment described under section 256.969, subdivision 2b,  
303.11 paragraph (k).

303.12 (c) Effective for services provided on or after July 1, 2003, rates that are based on the  
303.13 Medicare outpatient prospective payment system shall be replaced by a budget neutral  
303.14 prospective payment system that is derived using medical assistance data. The commissioner  
303.15 shall provide a proposal to the 2003 legislature to define and implement this provision.  
303.16 When implementing prospective payment methodologies, the commissioner shall use general  
303.17 methods and rate calculation parameters similar to the applicable Medicare prospective  
303.18 payment systems for services delivered in outpatient hospital and ambulatory surgical center  
303.19 settings unless other payment methodologies for these services are specified in this chapter.

303.20 (d) For fee-for-service services provided on or after July 1, 2002, the total payment,  
303.21 before third-party liability and spenddown, made to hospitals for outpatient hospital facility  
303.22 services is reduced by .5 percent from the current statutory rate.

303.23 (e) In addition to the reduction in paragraph (d), the total payment for fee-for-service  
303.24 services provided on or after July 1, 2003, made to hospitals for outpatient hospital facility  
303.25 services before third-party liability and spenddown, is reduced five percent from the current  
303.26 statutory rates. Facilities defined under section 256.969, subdivision 16, are excluded from  
303.27 this paragraph.

303.28 (f) In addition to the reductions in paragraphs (d) and (e), the total payment for  
303.29 fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient  
303.30 hospital facility services before third-party liability and spenddown, is reduced three percent  
303.31 from the current statutory rates. Mental health services and facilities defined under section  
303.32 256.969, subdivision 16, are excluded from this paragraph.

304.1 Sec. 9. Minnesota Statutes 2022, section 297F.10, subdivision 1, is amended to read:

304.2 Subdivision 1. **Tax and use tax on cigarettes.** Revenue received from cigarette taxes,  
304.3 as well as related penalties, interest, license fees, and miscellaneous sources of revenue  
304.4 shall be deposited by the commissioner in the state treasury and credited as follows:

304.5 (1) \$22,250,000 each year must be credited to the Academic Health Center special  
304.6 revenue fund hereby created and is annually appropriated to the Board of Regents at the  
304.7 University of Minnesota for Academic Health Center funding at the University of Minnesota;  
304.8 and

304.9 (2) ~~\$3,937,000~~ \$3,788,000 each year must be credited to the medical education and  
304.10 research costs account hereby created in the special revenue fund and is annually appropriated  
304.11 to the commissioner of health for distribution under section 62J.692, subdivision 4, paragraph  
304.12 (a); and

304.13 (3) the balance of the revenues derived from taxes, penalties, and interest (under this  
304.14 chapter) and from license fees and miscellaneous sources of revenue shall be credited to  
304.15 the general fund.

304.16 Sec. 10. **REPEALER.**

304.17 Minnesota Statutes 2022, sections 62J.692, subdivisions 4a, 7, and 7a; 137.38, subdivision  
304.18 1; and 256B.69, subdivision 5c, are repealed.

## 304.19 ARTICLE 5

### 304.20 HEALTH-RELATED LICENSING BOARDS

304.21 Section 1. Minnesota Statutes 2022, section 144E.001, subdivision 1, is amended to read:

304.22 Subdivision 1. **Scope.** For the purposes of ~~sections 144E.001 to 144E.52~~ this chapter,  
304.23 the terms defined in this section have the meanings given them.

304.24 Sec. 2. Minnesota Statutes 2022, section 144E.001, is amended by adding a subdivision  
304.25 to read:

304.26 Subd. 8b. **Medical resource communication center.** "Medical resource communication  
304.27 center" means an entity that:

304.28 (1) facilitates hospital-to-ambulance communications for ambulance services, the regional  
304.29 emergency medical services systems, and the board by coordinating patient care and  
304.30 transportation for ground and air operations;

305.1 (2) is integrated with the state's Allied Radio Matrix for Emergency Response (ARMER)  
305.2 radio system; and

305.3 (3) is the point of contact and a communication resource for statewide public safety  
305.4 entities, hospitals, and communities.

305.5 Sec. 3. Minnesota Statutes 2022, section 144E.101, subdivision 6, is amended to read:

305.6 Subd. 6. **Basic life support.** (a) Except as provided in paragraph (e), a basic life-support  
305.7 ambulance shall be staffed by at least two EMTs, one of whom must accompany the patient  
305.8 and provide a level of care so as to ensure that:

305.9 (1) life-threatening situations and potentially serious injuries are recognized;

305.10 (2) patients are protected from additional hazards;

305.11 (3) basic treatment to reduce the seriousness of emergency situations is administered;

305.12 and

305.13 (4) patients are transported to an appropriate medical facility for treatment.

305.14 (b) A basic life-support service shall provide basic airway management.

305.15 (c) A basic life-support service shall provide automatic defibrillation.

305.16 (d) A basic life-support service licensee's medical director may authorize ambulance  
305.17 service personnel to perform intravenous infusion and use equipment that is within the  
305.18 licensure level of the ambulance service, ~~including~~. A basic life-support licensee's medical  
305.19 director must authorize ambulance service personnel to perform administration of an opiate  
305.20 antagonist. Ambulance service personnel must be properly trained. Documentation of  
305.21 authorization for use, guidelines for use, continuing education, and skill verification must  
305.22 be maintained in the licensee's files.

305.23 (e) For emergency ambulance calls and interfacility transfers, an ambulance service may  
305.24 staff its basic life-support ambulances with one EMT, who must accompany the patient,  
305.25 and one registered emergency medical responder driver. For purposes of this paragraph,  
305.26 "ambulance service" means either an ambulance service whose primary service area is  
305.27 mainly located outside the metropolitan counties listed in section 473.121, subdivision 4,  
305.28 and outside the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud; or an  
305.29 ambulance service based in a community with a population of less than 2,500.

306.1 Sec. 4. Minnesota Statutes 2022, section 144E.101, subdivision 7, is amended to read:

306.2 Subd. 7. **Advanced life support.** (a) Except as provided in paragraphs (f) and (g), an  
306.3 advanced life-support ambulance shall be staffed by at least:

306.4 (1) one EMT or one AEMT and one paramedic;

306.5 (2) one EMT or one AEMT and one registered nurse who is an EMT or an AEMT, is  
306.6 currently practicing nursing, and has passed a paramedic practical skills test approved by  
306.7 the board and administered by an education program; or

306.8 (3) one EMT or one AEMT and one physician assistant who is an EMT or an AEMT,  
306.9 is currently practicing as a physician assistant, and has passed a paramedic practical skills  
306.10 test approved by the board and administered by an education program.

306.11 (b) An advanced life-support service shall provide basic life support, as specified under  
306.12 subdivision 6, paragraph (a), advanced airway management, manual defibrillation, ~~and~~  
306.13 administration of intravenous fluids and pharmaceuticals, and administration of opiate  
306.14 antagonists.

306.15 (c) In addition to providing advanced life support, an advanced life-support service may  
306.16 staff additional ambulances to provide basic life support according to subdivision 6 and  
306.17 section 144E.103, subdivision 1.

306.18 (d) An ambulance service providing advanced life support shall have a written agreement  
306.19 with its medical director to ensure medical control for patient care 24 hours a day, seven  
306.20 days a week. The terms of the agreement shall include a written policy on the administration  
306.21 of medical control for the service. The policy shall address the following issues:

306.22 (1) two-way communication for physician direction of ambulance service personnel;

306.23 (2) patient triage, treatment, and transport;

306.24 (3) use of standing orders; and

306.25 (4) the means by which medical control will be provided 24 hours a day.

306.26 The agreement shall be signed by the licensee's medical director and the licensee or the  
306.27 licensee's designee and maintained in the files of the licensee.

306.28 (e) When an ambulance service provides advanced life support, the authority of a  
306.29 paramedic, Minnesota registered nurse-EMT, or Minnesota registered physician  
306.30 assistant-EMT to determine the delivery of patient care prevails over the authority of an  
306.31 EMT.

307.1 (f) Upon application from an ambulance service that includes evidence demonstrating  
307.2 hardship, the board may grant a variance from the staff requirements in paragraph (a), clause  
307.3 (1), and may authorize an advanced life-support ambulance to be staffed by a registered  
307.4 emergency medical responder driver with a paramedic for all emergency calls and interfacility  
307.5 transfers. The variance shall apply to advanced life-support ambulance services until the  
307.6 ambulance service renews its license. When the variance expires, an ambulance service  
307.7 may apply for a new variance under this paragraph. This paragraph applies only to an  
307.8 ambulance service whose primary service area is mainly located outside the metropolitan  
307.9 counties listed in section 473.121, subdivision 4, and outside the cities of Duluth, Mankato,  
307.10 Moorhead, Rochester, and St. Cloud, or an ambulance based in a community with a  
307.11 population of less than 1,000 persons.

307.12 (g) After an initial emergency ambulance call, each subsequent emergency ambulance  
307.13 response, until the initial ambulance is again available, and interfacility transfers, may be  
307.14 staffed by one registered emergency medical responder driver and an EMT or paramedic.  
307.15 This paragraph applies only to an ambulance service whose primary service area is mainly  
307.16 located outside the metropolitan counties listed in section 473.121, subdivision 4, and outside  
307.17 the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud, or an ambulance based  
307.18 in a community with a population of less than 1,000 persons.

307.19 Sec. 5. Minnesota Statutes 2022, section 144E.103, subdivision 1, is amended to read:

307.20 Subdivision 1. **General requirements.** Every ambulance in service for patient care shall  
307.21 carry, at a minimum:

307.22 (1) oxygen;

307.23 (2) airway maintenance equipment in various sizes to accommodate all age groups;

307.24 (3) splinting equipment in various sizes to accommodate all age groups;

307.25 (4) dressings, bandages, commercially manufactured tourniquets, and bandaging  
307.26 equipment;

307.27 (5) an emergency obstetric kit;

307.28 (6) equipment to determine vital signs in various sizes to accommodate all age groups;

307.29 (7) a stretcher;

307.30 (8) a defibrillator; ~~and~~

307.31 (9) a fire extinguisher; and

308.1 (10) opiate antagonists.

308.2 Sec. 6. Minnesota Statutes 2022, section 144E.35, is amended to read:

308.3 **144E.35 REIMBURSEMENT TO ~~NONPROFIT~~ AMBULANCE SERVICES FOR**  
308.4 **VOLUNTEER EDUCATION COSTS.**

308.5 Subdivision 1. **Repayment for volunteer education.** A licensed ambulance service  
308.6 shall be reimbursed by the board for the necessary expense of the initial education of a  
308.7 volunteer ambulance attendant upon successful completion by the attendant of an EMT  
308.8 education course, or a continuing education course for EMT care, or both, which has been  
308.9 approved by the board, pursuant to section 144E.285. Reimbursement may include tuition,  
308.10 transportation, food, lodging, hourly payment for the time spent in the education course,  
308.11 and other necessary expenditures, except that in no instance shall a volunteer ambulance  
308.12 attendant be reimbursed more than ~~\$600~~ \$900 for successful completion of an initial  
308.13 education course, and ~~\$275~~ \$375 for successful completion of a continuing education course.

308.14 Subd. 2. **Reimbursement provisions.** Reimbursement ~~will~~ must be paid under provisions  
308.15 of this section when documentation is provided to the board that the individual has served  
308.16 for one year from the date of the final certification exam as an active member of a Minnesota  
308.17 licensed ambulance service.

308.18 Sec. 7. **[144E.53] MEDICAL RESOURCE COMMUNICATION CENTER GRANTS.**

308.19 The board shall distribute medical resource communication center grants annually to  
308.20 the two medical resource communication centers that were in operation in the state prior to  
308.21 January 1, 2000.

308.22 Sec. 8. Minnesota Statutes 2022, section 147.02, subdivision 1, is amended to read:

308.23 Subdivision 1. **United States or Canadian medical school graduates.** The board shall  
308.24 issue a license to practice medicine to a person not currently licensed in another state or  
308.25 Canada and who meets the requirements in paragraphs (a) to (i).

308.26 (a) An applicant for a license shall file a written application on forms provided by the  
308.27 board, showing to the board's satisfaction that the applicant is of good moral character and  
308.28 satisfies the requirements of this section.

308.29 (b) The applicant shall present evidence satisfactory to the board of being a graduate of  
308.30 a medical or osteopathic medical school located in the United States, its territories or Canada,  
308.31 and approved by the board based upon its faculty, curriculum, facilities, accreditation by a

309.1 recognized national accrediting organization approved by the board, and other relevant data,  
309.2 or is currently enrolled in the final year of study at the school.

309.3 (c) The applicant must have passed an examination as described in clause (1) or (2).

309.4 (1) The applicant must have passed a comprehensive examination for initial licensure  
309.5 prepared and graded by the National Board of Medical Examiners, the Federation of State  
309.6 Medical Boards, the Medical Council of Canada, the National Board of Osteopathic  
309.7 Examiners, or the appropriate state board that the board determines acceptable. The board  
309.8 shall by rule determine what constitutes a passing score in the examination.

309.9 (2) The applicant taking the United States Medical Licensing Examination (USMLE)  
309.10 or Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) must  
309.11 have passed steps or levels one, two, and three. Step or level three must be passed within  
309.12 five years of passing step or level two, or before the end of residency training. The applicant  
309.13 must pass each of steps or levels one, two, and three with passing scores as recommended  
309.14 by the USMLE program or National Board of Osteopathic Medical Examiners within three  
309.15 attempts. The applicant taking combinations of Federation of State Medical Boards, National  
309.16 Board of Medical Examiners, and USMLE may be accepted only if the combination is  
309.17 approved by the board as comparable to existing comparable examination sequences and  
309.18 all examinations are completed prior to the year 2000.

309.19 (d) The applicant shall present evidence satisfactory to the board of the completion of  
309.20 one year of graduate, clinical medical training in a program accredited by a national  
309.21 accrediting organization approved by the board ~~or other graduate training approved in~~  
309.22 ~~advance by the board as meeting standards similar to those of a national accrediting~~  
309.23 ~~organization.~~

309.24 (e) The applicant may make arrangements with the executive director to appear in person  
309.25 before the board or its designated representative to show that the applicant satisfies the  
309.26 requirements of this section. The board may establish as internal operating procedures the  
309.27 procedures or requirements for the applicant's personal presentation.

309.28 (f) The applicant shall pay a nonrefundable fee established by the board. Upon application  
309.29 or notice of license renewal, the board must provide notice to the applicant and to the person  
309.30 whose license is scheduled to be issued or renewed of any additional fees, surcharges, or  
309.31 other costs which the person is obligated to pay as a condition of licensure. The notice must:

309.32 (1) state the dollar amount of the additional costs; and

309.33 (2) clearly identify to the applicant the payment schedule of additional costs.

310.1 (g) The applicant must not be under license suspension or revocation by the licensing  
310.2 board of the state or jurisdiction in which the conduct that caused the suspension or revocation  
310.3 occurred.

310.4 (h) The applicant must not have engaged in conduct warranting disciplinary action  
310.5 against a licensee, or have been subject to disciplinary action other than as specified in  
310.6 paragraph (g). If the applicant does not satisfy the requirements stated in this paragraph,  
310.7 the board may issue a license only on the applicant's showing that the public will be protected  
310.8 through issuance of a license with conditions and limitations the board considers appropriate.

310.9 (i) If the examination in paragraph (c) was passed more than ten years ago, the applicant  
310.10 must either:

310.11 (1) pass the special purpose examination of the Federation of State Medical Boards with  
310.12 a score of 75 or better within three attempts; or

310.13 (2) have a current certification by a specialty board of the American Board of Medical  
310.14 Specialties, of the American Osteopathic Association, the Royal College of Physicians and  
310.15 Surgeons of Canada, or of the College of Family Physicians of Canada.

310.16 Sec. 9. Minnesota Statutes 2022, section 147.03, subdivision 1, is amended to read:

310.17 Subdivision 1. **Endorsement; reciprocity.** (a) The board may issue a license to practice  
310.18 medicine to any person who satisfies the requirements in paragraphs (b) to (e).

310.19 (b) The applicant shall satisfy all the requirements established in section 147.02,  
310.20 subdivision 1, paragraphs (a), (b), (d), (e), and (f), or section 147.037, subdivision 1,  
310.21 paragraphs (a) to (e).

310.22 (c) The applicant shall:

310.23 (1) have passed an examination prepared and graded by the Federation of State Medical  
310.24 Boards, the National Board of Medical Examiners, or the United States Medical Licensing  
310.25 Examination (USMLE) program in accordance with section 147.02, subdivision 1, paragraph  
310.26 (c), clause (2); the National Board of Osteopathic Medical Examiners; or the Medical Council  
310.27 of Canada; and

310.28 (2) have a current license from the equivalent licensing agency in another state or Canada  
310.29 and, if the examination in clause (1) was passed more than ten years ago, either:

310.30 (i) pass the Special Purpose Examination of the Federation of State Medical Boards ~~with~~  
310.31 ~~a score of 75 or better~~ (SPEX) within three attempts; or

311.1 (ii) have a current certification by a specialty board of the American Board of Medical  
311.2 Specialties, of the American Osteopathic Association, the Royal College of Physicians and  
311.3 Surgeons of Canada, or of the College of Family Physicians of Canada; or

311.4 (3) if the applicant fails to meet the requirement established in section 147.02, subdivision  
311.5 1, paragraph (c), clause (2), because the applicant failed to pass within the permitted three  
311.6 attempts each of steps or levels one, two, and three of the USMLE ~~within the required three~~  
311.7 ~~attempts~~ or the Comprehensive Osteopathic Medical Licensing Examination  
311.8 (COMLEX-USA), the applicant may be granted a license provided the applicant:

311.9 (i) has passed each of steps or levels one, two, and three within no more than four attempts  
311.10 for any of the three steps or levels with passing scores as recommended by the USMLE or  
311.11 COMLEX-USA program ~~within no more than four attempts for any of the three steps;~~

311.12 (ii) is currently licensed in another state; and

311.13 (iii) has current certification by a specialty board of the American Board of Medical  
311.14 Specialties, the American Osteopathic Association ~~Bureau of Professional Education~~, the  
311.15 Royal College of Physicians and Surgeons of Canada, or the College of Family Physicians  
311.16 of Canada.

311.17 (d) The applicant must not be under license suspension or revocation by the licensing  
311.18 board of the state or jurisdiction in which the conduct that caused the suspension or revocation  
311.19 occurred.

311.20 (e) The applicant must not have engaged in conduct warranting disciplinary action against  
311.21 a licensee, or have been subject to disciplinary action other than as specified in paragraph  
311.22 (d). If an applicant does not satisfy the requirements stated in this paragraph, the board may  
311.23 issue a license only on the applicant's showing that the public will be protected through  
311.24 issuance of a license with conditions or limitations the board considers appropriate.

311.25 (f) Upon the request of an applicant, the board may conduct the final interview of the  
311.26 applicant by teleconference.

311.27 Sec. 10. Minnesota Statutes 2022, section 147.037, subdivision 1, is amended to read:

311.28 Subdivision 1. **Requirements.** The board shall issue a license to practice medicine to  
311.29 any person who satisfies the requirements in paragraphs (a) to (g).

311.30 (a) The applicant shall satisfy all the requirements established in section 147.02,  
311.31 subdivision 1, paragraphs (a), (e), (f), (g), and (h).

312.1 (b) The applicant shall present evidence satisfactory to the board that the applicant is a  
312.2 graduate of a medical or osteopathic school approved by the board as equivalent to accredited  
312.3 United States or Canadian schools based upon its faculty, curriculum, facilities, accreditation,  
312.4 or other relevant data. If the applicant is a graduate of a medical or osteopathic program  
312.5 that is not accredited by the Liaison Committee for Medical Education or the American  
312.6 Osteopathic Association, the applicant may use the Federation of State Medical Boards'  
312.7 Federation Credentials Verification Service (FCVS) or its successor. If the applicant uses  
312.8 this service as allowed under this paragraph, the physician application fee may be less than  
312.9 \$200 but must not exceed the cost of administering this paragraph.

312.10 (c) The applicant shall present evidence satisfactory to the board that the applicant has  
312.11 been awarded a certificate by the Educational Council for Foreign Medical Graduates, and  
312.12 the applicant has a working ability in the English language sufficient to communicate with  
312.13 patients and physicians and to engage in the practice of medicine.

312.14 (d) The applicant shall present evidence satisfactory to the board of the completion of  
312.15 one year of graduate, clinical medical training in a program accredited by a national  
312.16 accrediting organization approved by the board ~~or other graduate training approved in~~  
312.17 ~~advance by the board as meeting standards similar to those of a national accrediting~~  
312.18 ~~organization.~~ This requirement does not apply to an applicant who is admitted pursuant to  
312.19 the rules of the United States Department of Labor and:

312.20 (1) ~~to an applicant who is~~ was admitted as a permanent immigrant to the United States  
312.21 on or before October 1, 1991, as a person of exceptional ability in the sciences according  
312.22 to Code of Federal Regulations, title 20, section 656.22(d); or

312.23 (2) ~~to an applicant holding~~ who holds a valid license to practice medicine in another  
312.24 country and was issued a permanent immigrant visa after October 1, 1991, as a person of  
312.25 extraordinary ability in the field of science or as an outstanding professor or researcher  
312.26 according to Code of Federal Regulations, title 8, section 204.5(h) and (i), or a temporary  
312.27 nonimmigrant visa as a person of extraordinary ability in the field of science according to  
312.28 Code of Federal Regulations, title 8, section 214.2(o);

312.29 ~~provided that a person under clause (1) or (2) is admitted pursuant to rules of the United~~  
312.30 ~~States Department of Labor.~~

312.31 (e) The applicant must:

312.32 (1) have passed an examination prepared and graded by the Federation of State Medical  
312.33 Boards, the United States Medical Licensing Examination (USMLE) program in accordance

313.1 with section 147.02, subdivision 1, paragraph (c), clause (2), or the Medical Council of  
313.2 Canada; and

313.3 (2) if the examination in clause (1) was passed more than ten years ago, either:

313.4 (i) pass the Special Purpose Examination of the Federation of State Medical Boards ~~with~~  
313.5 ~~a score of 75 or better within three attempts~~ (SPEX) or the Comprehensive Osteopathic  
313.6 Medical Variable-Purpose Examination of the National Board of Osteopathic Medical  
313.7 Examiners (COMVEX). The applicant must pass the SPEX or COMVEX within no more  
313.8 than three attempts of taking the SPEX, COMVEX, or a combination of the SPEX and  
313.9 COMVEX; or

313.10 (ii) have a current certification by a specialty board of the American Board of Medical  
313.11 Specialties, ~~of~~ the American Osteopathic Association, ~~of~~ the Royal College of Physicians  
313.12 and Surgeons of Canada, or ~~of~~ the College of Family Physicians of Canada; or

313.13 (3) if the applicant fails to meet the requirement established in section 147.02, subdivision  
313.14 1, paragraph (c), clause (2), because the applicant failed to pass within the permitted three  
313.15 attempts each of steps or levels one, two, and three of the USMLE ~~within the required three~~  
313.16 attempts or the Comprehensive Osteopathic Medical Licensing Examination  
313.17 (COMLEX-USA), the applicant may be granted a license provided the applicant:

313.18 (i) has passed each of steps or levels one, two, and three within no more than four attempts  
313.19 for any of the three steps or levels with passing scores as recommended by the USMLE or  
313.20 COMLEX-USA program ~~within no more than four attempts for any of the three steps;~~

313.21 (ii) is currently licensed in another state; and

313.22 (iii) has current certification by a specialty board of the American Board of Medical  
313.23 Specialties, the American Osteopathic Association, the Royal College of Physicians and  
313.24 Surgeons of Canada, or the College of Family Physicians of Canada.

313.25 (f) The applicant must not be under license suspension or revocation by the licensing  
313.26 board of the state or jurisdiction in which the conduct that caused the suspension or revocation  
313.27 occurred.

313.28 (g) The applicant must not have engaged in conduct warranting disciplinary action  
313.29 against a licensee; or have been subject to disciplinary action other than as specified in  
313.30 paragraph (f). If an applicant does not satisfy the requirements stated in this paragraph, the  
313.31 board may issue a license only on the applicant's showing that the public will be protected  
313.32 through issuance of a license with conditions or limitations the board considers appropriate.

314.1 Sec. 11. Minnesota Statutes 2022, section 147.141, is amended to read:

314.2 **147.141 FORMS OF DISCIPLINARY ACTION.**

314.3 When the board finds that a licensed physician or a physician registered under section  
314.4 147.032 has violated a provision or provisions of sections 147.01 to 147.22, it may do one  
314.5 or more of the following:

314.6 (1) revoke the license;

314.7 (2) suspend the license;

314.8 (3) revoke or suspend registration to perform interstate telehealth;

314.9 (4) impose limitations or conditions on the physician's practice of medicine, including  
314.10 limiting the limitation of scope of practice to designated field specialties; ~~the imposition of~~  
314.11 imposing retraining or rehabilitation requirements; ~~the requirement of~~ requiring practice  
314.12 under supervision; or ~~the conditioning of~~ continued practice on demonstration of knowledge  
314.13 or skills by appropriate examination or other review of skill and competence;

314.14 (5) impose a civil penalty not exceeding \$10,000 for each separate violation, the amount  
314.15 of the civil penalty to be fixed so as to deprive the physician of any economic advantage  
314.16 gained by reason of the violation charged or to reimburse the board for the cost of the  
314.17 investigation and proceeding;

314.18 (6) order the physician to provide unremunerated professional service under supervision  
314.19 at a designated public hospital, clinic, or other health care institution; or

314.20 (7) censure or reprimand the licensed physician.

314.21 Sec. 12. Minnesota Statutes 2022, section 147A.16, is amended to read:

314.22 **147A.16 FORMS OF DISCIPLINARY ACTION.**

314.23 (a) When the board finds that a licensed physician assistant has violated a provision of  
314.24 this chapter, it may do one or more of the following:

314.25 (1) revoke the license;

314.26 (2) suspend the license;

314.27 (3) impose limitations or conditions on the physician assistant's practice, including  
314.28 limiting the scope of practice to designated field specialties; imposing retraining or  
314.29 rehabilitation requirements; or limiting practice until demonstration of knowledge or skills  
314.30 by appropriate examination or other review of skill and competence;

315.1 (4) impose a civil penalty not exceeding \$10,000 for each separate violation, the amount  
 315.2 of the civil penalty to be fixed so as to deprive the physician assistant of any economic  
 315.3 advantage gained by reason of the violation charged or to reimburse the board for the cost  
 315.4 of the investigation and proceeding; or

315.5 (5) censure or reprimand the licensed physician assistant.

315.6 (b) Upon judicial review of any board disciplinary action taken under this chapter, the  
 315.7 reviewing court shall seal the administrative record, except for the board's final decision,  
 315.8 and shall not make the administrative record available to the public.

315.9 Sec. 13. Minnesota Statutes 2022, section 147B.02, subdivision 4, is amended to read:

315.10 Subd. 4. **Exceptions.** (a) The following persons may practice acupuncture within the  
 315.11 scope of their practice without an acupuncture license:

315.12 (1) a physician licensed under chapter 147;

315.13 (2) an osteopathic physician licensed under chapter 147;

315.14 (3) a chiropractor licensed under chapter 148;

315.15 ~~(4) a person who is studying in a formal course of study or tutorial intern program~~  
 315.16 ~~approved by the acupuncture advisory council established in section 147B.05 so long as~~  
 315.17 ~~the person's acupuncture practice is supervised by a licensed acupuncturist or a person who~~  
 315.18 ~~is exempt under clause (5);~~

315.19 ~~(5)~~ (4) a visiting acupuncturist practicing acupuncture within an instructional setting for  
 315.20 the sole purpose of teaching at a school registered with the Minnesota Office of Higher  
 315.21 Education, who may practice without a license for a period of one year, with two one-year  
 315.22 extensions permitted; and

315.23 ~~(6)~~ (5) a visiting acupuncturist who is in the state for the sole purpose of providing a  
 315.24 tutorial or workshop not to exceed 30 days in one calendar year.

315.25 (b) This chapter does not prohibit a person who does not have an acupuncturist license  
 315.26 from practicing specific noninvasive techniques, such as acupressure, that are within the  
 315.27 scope of practice as set forth in section 147B.06, subdivision 4.

315.28 Sec. 14. Minnesota Statutes 2022, section 147B.02, subdivision 7, is amended to read:

315.29 Subd. 7. **Licensure requirements.** (a) ~~After June 30, 1997,~~ An applicant for licensure  
 315.30 must:

316.1 (1) submit a completed application for licensure on forms provided by the board, which  
316.2 must include the applicant's name and address of record, which shall be public;

316.3 (2) unless licensed under subdivision 5 or 6, submit ~~a notarized copy of a~~ evidence  
316.4 satisfactory to the board of current NCCAOM certification;

316.5 (3) sign a statement that the information in the application is true and correct to the best  
316.6 of the applicant's knowledge and belief;

316.7 (4) submit with the application all fees required; and

316.8 (5) sign a waiver authorizing the board to obtain access to the applicant's records in this  
316.9 state or any state in which the applicant has engaged in the practice of acupuncture.

316.10 (b) The board may ask the applicant to provide any additional information necessary to  
316.11 ensure that the applicant is able to practice with reasonable skill and safety to the public.

316.12 (c) The board may investigate information provided by an applicant to determine whether  
316.13 the information is accurate and complete. The board shall notify an applicant of action taken  
316.14 on the application and the reasons for denying licensure if licensure is denied.

316.15 Sec. 15. [148.635] FEE.

316.16 Subdivision 1. Nonrefundable fee. The fee in this section is nonrefundable.

316.17 Subd. 2. Licensure verification fee. The fee for verification of licensure is \$20.

316.18 Sec. 16. Minnesota Statutes 2022, section 148B.392, subdivision 2, is amended to read:

316.19 Subd. 2. **Licensure and application fees.** Licensure and application fees established  
316.20 by the board shall not exceed the following amounts:

316.21 (1) application fee for national examination is ~~\$110~~ \$150;

316.22 (2) application fee for Licensed Marriage and Family Therapist (LMFT) state examination  
316.23 is ~~\$110~~ \$150;

316.24 (3) initial LMFT license fee is prorated, but cannot exceed \$125;

316.25 (4) annual renewal fee for LMFT license is ~~\$125~~ \$225;

316.26 (5) late fee for LMFT license renewal is ~~\$50~~ \$100;

316.27 (6) application fee for LMFT licensure by reciprocity is ~~\$220~~ \$300;

316.28 (7) fee for initial Licensed Associate Marriage and Family Therapist (LAMFT) license  
316.29 is ~~\$75~~ \$100;

- 317.1 (8) annual renewal fee for LAMFT license is ~~\$75~~ \$100;
- 317.2 (9) late fee for LAMFT renewal is ~~\$25~~ \$50;
- 317.3 (10) fee for reinstatement of license is \$150;
- 317.4 (11) fee for emeritus status is ~~\$125~~ \$225; and
- 317.5 (12) fee for temporary license for members of the military is \$100.

317.6 Sec. 17. Minnesota Statutes 2022, section 148F.11, is amended by adding a subdivision  
317.7 to read:

317.8 Subd. 2a. Former students. (a) A former student may practice alcohol and drug  
317.9 counseling for 90 days from the former student's degree conferral date from an accredited  
317.10 school or educational program or from the last date the former student received credit for  
317.11 an alcohol and drug counseling course from an accredited school or educational program.  
317.12 The former student's practice must be supervised by an alcohol and drug counselor or an  
317.13 alcohol and drug counselor supervisor, as defined in section 245G.11. The former student's  
317.14 practice is limited to the site where the student completed their internship or practicum. A  
317.15 former student must be paid for work performed during the 90-day period.

317.16 (b) The former student's right to practice automatically expires after 90 days from the  
317.17 former student's degree conferral date or date of last course credit for an alcohol and drug  
317.18 counseling course, whichever occurs last.

317.19 Sec. 18. Minnesota Statutes 2022, section 150A.08, subdivision 1, is amended to read:

317.20 Subdivision 1. **Grounds.** The board may refuse or by order suspend or revoke, limit or  
317.21 modify by imposing conditions it deems necessary, the license of a dentist, dental therapist,  
317.22 dental hygienist, or dental ~~assisting~~ assistant upon any of the following grounds:

317.23 (1) fraud or deception in connection with the practice of dentistry or the securing of a  
317.24 license certificate;

317.25 (2) conviction, including a finding or verdict of guilt, an admission of guilt, or a no  
317.26 contest plea, in any court of a felony or gross misdemeanor reasonably related to the practice  
317.27 of dentistry as evidenced by a certified copy of the conviction;

317.28 (3) conviction, including a finding or verdict of guilt, an admission of guilt, or a no  
317.29 contest plea, in any court of an offense involving moral turpitude as evidenced by a certified  
317.30 copy of the conviction;

317.31 (4) habitual overindulgence in the use of intoxicating liquors;

318.1 (5) improper or unauthorized prescription, dispensing, administering, or personal or  
318.2 other use of any legend drug as defined in chapter 151, of any chemical as defined in chapter  
318.3 151, or of any controlled substance as defined in chapter 152;

318.4 (6) conduct unbecoming a person licensed to practice dentistry, dental therapy, dental  
318.5 hygiene, or dental assisting, or conduct contrary to the best interest of the public, as such  
318.6 conduct is defined by the rules of the board;

318.7 (7) gross immorality;

318.8 (8) any physical, mental, emotional, or other disability which adversely affects a dentist's,  
318.9 dental therapist's, dental hygienist's, or dental assistant's ability to perform the service for  
318.10 which the person is licensed;

318.11 (9) revocation or suspension of a license or equivalent authority to practice, or other  
318.12 disciplinary action or denial of a license application taken by a licensing or credentialing  
318.13 authority of another state, territory, or country as evidenced by a certified copy of the  
318.14 licensing authority's order, if the disciplinary action or application denial was based on facts  
318.15 that would provide a basis for disciplinary action under this chapter and if the action was  
318.16 taken only after affording the credentialed person or applicant notice and opportunity to  
318.17 refute the allegations or pursuant to stipulation or other agreement;

318.18 (10) failure to maintain adequate safety and sanitary conditions for a dental office in  
318.19 accordance with the standards established by the rules of the board;

318.20 (11) employing, assisting, or enabling in any manner an unlicensed person to practice  
318.21 dentistry;

318.22 (12) failure or refusal to attend, testify, and produce records as directed by the board  
318.23 under subdivision 7;

318.24 (13) violation of, or failure to comply with, any other provisions of sections 150A.01 to  
318.25 150A.12, the rules of the Board of Dentistry, or any disciplinary order issued by the board,  
318.26 sections 144.291 to 144.298 or 595.02, subdivision 1, paragraph (d), or for any other just  
318.27 cause related to the practice of dentistry. Suspension, revocation, modification or limitation  
318.28 of any license shall not be based upon any judgment as to therapeutic or monetary value of  
318.29 any individual drug prescribed or any individual treatment rendered, but only upon a repeated  
318.30 pattern of conduct;

318.31 (14) knowingly providing false or misleading information that is directly related to the  
318.32 care of that patient unless done for an accepted therapeutic purpose such as the administration  
318.33 of a placebo; or

319.1 (15) aiding suicide or aiding attempted suicide in violation of section 609.215 as  
319.2 established by any of the following:

319.3 (i) a copy of the record of criminal conviction or plea of guilty for a felony in violation  
319.4 of section 609.215, subdivision 1 or 2;

319.5 (ii) a copy of the record of a judgment of contempt of court for violating an injunction  
319.6 issued under section 609.215, subdivision 4;

319.7 (iii) a copy of the record of a judgment assessing damages under section 609.215,  
319.8 subdivision 5; or

319.9 (iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2.  
319.10 The board shall investigate any complaint of a violation of section 609.215, subdivision 1  
319.11 or 2.

319.12 Sec. 19. Minnesota Statutes 2022, section 150A.08, subdivision 5, is amended to read:

319.13 Subd. 5. **Medical examinations.** If the board has probable cause to believe that a dentist,  
319.14 dental therapist, dental hygienist, dental assistant, or applicant engages in acts described in  
319.15 subdivision 1, clause (4) or (5), or has a condition described in subdivision 1, clause (8), it  
319.16 shall direct the dentist, dental therapist, dental hygienist, dental assistant, or applicant to  
319.17 submit to a mental or physical examination or a substance use disorder assessment. For the  
319.18 purpose of this subdivision, every dentist, dental therapist, dental hygienist, or dental assistant  
319.19 licensed under this chapter or person submitting an application for a license is deemed to  
319.20 have given consent to submit to a mental or physical examination when directed in writing  
319.21 by the board and to have waived all objections in any proceeding under this section to the  
319.22 admissibility of the examining physician's testimony or examination reports on the ground  
319.23 that they constitute a privileged communication. Failure to submit to an examination without  
319.24 just cause may result in an application being denied or a default and final order being entered  
319.25 without the taking of testimony or presentation of evidence, other than evidence which may  
319.26 be submitted by affidavit, that the licensee or applicant did not submit to the examination.  
319.27 A dentist, dental therapist, dental hygienist, dental assistant, or applicant affected under this  
319.28 section shall at reasonable intervals be afforded an opportunity to demonstrate ability to  
319.29 start or resume the competent practice of dentistry or perform the duties of a dental therapist,  
319.30 dental hygienist, or dental assistant with reasonable skill and safety to patients. In any  
319.31 proceeding under this subdivision, neither the record of proceedings nor the orders entered  
319.32 by the board is admissible, is subject to subpoena, or may be used against the dentist, dental  
319.33 therapist, dental hygienist, dental assistant, or applicant in any proceeding not commenced

320.1 by the board. Information obtained under this subdivision shall be classified as private  
320.2 pursuant to the Minnesota Government Data Practices Act.

320.3 Sec. 20. Minnesota Statutes 2022, section 150A.091, is amended by adding a subdivision  
320.4 to read:

320.5 Subd. 23. **Mailing list services.** Each licensee must submit a nonrefundable \$5 fee to  
320.6 request a mailing address list.

320.7 Sec. 21. Minnesota Statutes 2022, section 150A.13, subdivision 10, is amended to read:

320.8 Subd. 10. **Failure to report.** ~~On or after August 1, 2012,~~ Any person, institution, insurer,  
320.9 or organization that fails to report as required under subdivisions 2 to 6 shall be subject to  
320.10 civil penalties for failing to report as required by law.

320.11 Sec. 22. Minnesota Statutes 2022, section 151.01, subdivision 27, is amended to read:

320.12 Subd. 27. **Practice of pharmacy.** (a) "Practice of pharmacy" means:

320.13 (1) interpretation and evaluation of prescription drug orders;

320.14 (2) compounding, labeling, and dispensing drugs and devices (except labeling by a  
320.15 manufacturer or packager of nonprescription drugs or commercially packaged legend drugs  
320.16 and devices);

320.17 (3) participation in clinical interpretations and monitoring of drug therapy for assurance  
320.18 of safe and effective use of drugs, including the performance of laboratory tests that are  
320.19 waived under the federal Clinical Laboratory Improvement Act of 1988, United States Code,  
320.20 title 42, section 263a et seq., provided that a pharmacist may interpret the results of laboratory  
320.21 tests but may modify drug therapy only pursuant to a protocol or collaborative practice  
320.22 agreement;

320.23 (4) participation in drug and therapeutic device selection; drug administration for first  
320.24 dosage and medical emergencies; intramuscular and subcutaneous drug administration under  
320.25 a prescription drug order; drug regimen reviews; and drug or drug-related research;

320.26 (5) drug administration, through intramuscular and subcutaneous administration used  
320.27 to treat mental illnesses as permitted under the following conditions:

320.28 (i) upon the order of a prescriber and the prescriber is notified after administration is  
320.29 complete; or

321.1 (ii) pursuant to a protocol or collaborative practice agreement as defined by section  
321.2 151.01, subdivisions 27b and 27c, and participation in the initiation, management,  
321.3 modification, administration, and discontinuation of drug therapy is according to the protocol  
321.4 or collaborative practice agreement between the pharmacist and a dentist, optometrist,  
321.5 physician, physician assistant, podiatrist, or veterinarian, or an advanced practice registered  
321.6 nurse authorized to prescribe, dispense, and administer under section 148.235. Any changes  
321.7 in drug therapy or medication administration made pursuant to a protocol or collaborative  
321.8 practice agreement must be documented by the pharmacist in the patient's medical record  
321.9 or reported by the pharmacist to a practitioner responsible for the patient's care;

321.10 (6) participation in administration of influenza vaccines and vaccines authorized or  
321.11 approved by the United States Food and Drug Administration related to COVID-19 or  
321.12 SARS-CoV-2 to all eligible individuals six years of age and older and all other vaccines to  
321.13 patients 13 years of age and older by written protocol with a physician licensed under chapter  
321.14 147, a physician assistant authorized to prescribe drugs under chapter 147A, or an advanced  
321.15 practice registered nurse authorized to prescribe drugs under section 148.235, provided that:

321.16 (i) the protocol includes, at a minimum:

321.17 (A) the name, dose, and route of each vaccine that may be given;

321.18 (B) the patient population for whom the vaccine may be given;

321.19 (C) contraindications and precautions to the vaccine;

321.20 (D) the procedure for handling an adverse reaction;

321.21 (E) the name, signature, and address of the physician, physician assistant, or advanced  
321.22 practice registered nurse;

321.23 (F) a telephone number at which the physician, physician assistant, or advanced practice  
321.24 registered nurse can be contacted; and

321.25 (G) the date and time period for which the protocol is valid;

321.26 (ii) the pharmacist has successfully completed a program approved by the Accreditation  
321.27 Council for Pharmacy Education (ACPE) specifically for the administration of immunizations  
321.28 or a program approved by the board;

321.29 (iii) the pharmacist utilizes the Minnesota Immunization Information Connection to  
321.30 assess the immunization status of individuals prior to the administration of vaccines, except  
321.31 when administering influenza vaccines to individuals age nine and older;

322.1 (iv) the pharmacist reports the administration of the immunization to the Minnesota  
322.2 Immunization Information Connection; ~~and~~

322.3 (v) the pharmacist complies with guidelines for vaccines and immunizations established  
322.4 by the federal Advisory Committee on Immunization Practices, except that a pharmacist  
322.5 does not need to comply with those portions of the guidelines that establish immunization  
322.6 schedules when administering a vaccine pursuant to a valid, patient-specific order issued  
322.7 by a physician licensed under chapter 147, a physician assistant authorized to prescribe  
322.8 drugs under chapter 147A, or an advanced practice registered nurse authorized to prescribe  
322.9 drugs under section 148.235, provided that the order is consistent with the United States  
322.10 Food and Drug Administration approved labeling of the vaccine; and

322.11 (vi) the pharmacist has a current certificate in cardiopulmonary resuscitation;

322.12 (7) participation in the initiation, management, modification, and discontinuation of  
322.13 drug therapy according to a written protocol or collaborative practice agreement between:

322.14 (i) one or more pharmacists and one or more dentists, optometrists, physicians, physician  
322.15 assistants, podiatrists, or veterinarians; or (ii) one or more pharmacists and one or more  
322.16 physician assistants authorized to prescribe, dispense, and administer under chapter 147A,  
322.17 or advanced practice registered nurses authorized to prescribe, dispense, and administer  
322.18 under section 148.235. Any changes in drug therapy made pursuant to a protocol or  
322.19 collaborative practice agreement must be documented by the pharmacist in the patient's  
322.20 medical record or reported by the pharmacist to a practitioner responsible for the patient's  
322.21 care;

322.22 (8) participation in the storage of drugs and the maintenance of records;

322.23 (9) patient counseling on therapeutic values, content, hazards, and uses of drugs and  
322.24 devices;

322.25 (10) offering or performing those acts, services, operations, or transactions necessary  
322.26 in the conduct, operation, management, and control of a pharmacy;

322.27 (11) participation in the initiation, management, modification, and discontinuation of  
322.28 therapy with opiate antagonists, as defined in section 604A.04, subdivision 1, pursuant to:

322.29 (i) a written protocol as allowed under clause (7); or

322.30 (ii) a written protocol with a community health board medical consultant or a practitioner  
322.31 designated by the commissioner of health, as allowed under section 151.37, subdivision 13;

323.1 (12) prescribing self-administered hormonal contraceptives; nicotine replacement  
323.2 medications; and opiate antagonists for the treatment of an acute opiate overdose pursuant  
323.3 to section 151.37, subdivision 14, 15, or 16; and

323.4 (13) participation in the placement of drug monitoring devices according to a prescription,  
323.5 protocol, or collaborative practice agreement.

323.6 (b) A pharmacist may delegate the authority to administer vaccines under paragraph (a),  
323.7 clause 6, to a pharmacy technician or pharmacist intern who has completed training in  
323.8 vaccine administration if:

323.9 (1) the pharmacy technician or pharmacist intern has successfully completed a program  
323.10 approved by the ACPE specifically for the administration of immunizations or a program  
323.11 approved by the board;

323.12 (2) the pharmacy technician or pharmacist intern has a current certificate in  
323.13 cardiopulmonary resuscitation;

323.14 (3) the pharmacist intern has the ability, under the direct supervision of a pharmacist,  
323.15 to utilize the Minnesota Immunization Information Connection to assess the immunization  
323.16 status of individuals prior to the administration of vaccines, except when administering  
323.17 influenza vaccines to individuals age nine and older;

323.18 (4) the pharmacy technician has completed a minimum of two hours of ACPE-approved,  
323.19 immunization-related continuing pharmacy education as part of the pharmacy technician's  
323.20 two-year continuing education schedule;

323.21 (5) the pharmacy technician has completed one of the training programs listed under  
323.22 Minnesota Rules, part 6800.3850, subpart 1h, item B; and

323.23 (6) the pharmacy technician or pharmacist intern administering vaccinations is supervised  
323.24 by a licensed pharmacist according to the following requirements:

323.25 (i) the supervising pharmacist is readily and immediately available to the immunizing  
323.26 pharmacy technician or pharmacist intern; and

323.27 (ii) direct supervision under this clause is provided in person and not through telehealth,  
323.28 as defined under section 62A.673, subdivision 2.

323.29 Sec. 23. Minnesota Statutes 2022, section 151.065, subdivision 1, is amended to read:

323.30 Subdivision 1. **Application fees.** Application fees for licensure and registration are as  
323.31 follows:

- 324.1 (1) pharmacist licensed by examination, ~~\$175~~ \$210;
- 324.2 (2) pharmacist licensed by reciprocity, ~~\$275~~ \$300;
- 324.3 (3) pharmacy intern, ~~\$50~~ \$75;
- 324.4 (4) pharmacy technician, ~~\$50~~ \$60;
- 324.5 (5) pharmacy, ~~\$260~~ \$300;
- 324.6 (6) drug wholesaler, legend drugs only, ~~\$5,260~~ \$5,300;
- 324.7 (7) drug wholesaler, legend and nonlegend drugs, ~~\$5,260~~ \$5,300;
- 324.8 (8) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~\$5,260~~ \$5,300;
- 324.9 (9) drug wholesaler, medical gases, ~~\$5,260~~ \$5,300 for the first facility and ~~\$260~~ \$300
- 324.10 for each additional facility;
- 324.11 (10) third-party logistics provider, ~~\$260~~ \$300;
- 324.12 (11) drug manufacturer, nonopiate legend drugs only, ~~\$5,260~~ \$5,300;
- 324.13 (12) drug manufacturer, nonopiate legend and nonlegend drugs, ~~\$5,260~~ \$5,300;
- 324.14 (13) drug manufacturer, nonlegend or veterinary legend drugs, ~~\$5,260~~ \$5,300;
- 324.15 (14) drug manufacturer, medical gases, ~~\$5,260~~ \$5,300 for the first facility and ~~\$260~~
- 324.16 \$300 for each additional facility;
- 324.17 (15) drug manufacturer, also licensed as a pharmacy in Minnesota, ~~\$5,260~~ \$5,300;
- 324.18 (16) drug manufacturer of opiate-containing controlled substances listed in section
- 324.19 152.02, subdivisions 3 to 5, ~~\$55,260~~ \$55,300;
- 324.20 (17) medical gas dispenser, \$260;
- 324.21 (18) controlled substance researcher, ~~\$75~~ \$150; and
- 324.22 (19) pharmacy professional corporation, \$150.

324.23 Sec. 24. Minnesota Statutes 2022, section 151.065, subdivision 2, is amended to read:

324.24 Subd. 2. **Original license fee.** The pharmacist original licensure fee, ~~\$175~~ \$210.

324.25 Sec. 25. Minnesota Statutes 2022, section 151.065, subdivision 3, is amended to read:

324.26 Subd. 3. **Annual renewal fees.** Annual licensure and registration renewal fees are as

324.27 follows:

- 325.1 (1) pharmacist, ~~\$175~~ \$210;
- 325.2 (2) pharmacy technician, ~~\$50~~ \$60;
- 325.3 (3) pharmacy, ~~\$260~~ \$300;
- 325.4 (4) drug wholesaler, legend drugs only, ~~\$5,260~~ \$5,300;
- 325.5 (5) drug wholesaler, legend and nonlegend drugs, ~~\$5,260~~ \$5,300;
- 325.6 (6) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~\$5,260~~ \$5,300;
- 325.7 (7) drug wholesaler, medical gases, ~~\$5,260~~ \$5,300 for the first facility and ~~\$260~~ \$300
- 325.8 for each additional facility;
- 325.9 (8) third-party logistics provider, ~~\$260~~ \$300;
- 325.10 (9) drug manufacturer, nonopiate legend drugs only, ~~\$5,260~~ \$5,300;
- 325.11 (10) drug manufacturer, nonopiate legend and nonlegend drugs, ~~\$5,260~~ \$5,300;
- 325.12 (11) drug manufacturer, nonlegend, veterinary legend drugs, or both, ~~\$5,260~~ \$5,300;
- 325.13 (12) drug manufacturer, medical gases, ~~\$5,260~~ \$5,300 for the first facility and ~~\$260~~
- 325.14 \$300 for each additional facility;
- 325.15 (13) drug manufacturer, also licensed as a pharmacy in Minnesota, ~~\$5,260~~ \$5,300;
- 325.16 (14) drug manufacturer of opiate-containing controlled substances listed in section
- 325.17 152.02, subdivisions 3 to 5, ~~\$55,260~~ \$55,300;
- 325.18 (15) medical gas dispenser, \$260;
- 325.19 (16) controlled substance researcher, ~~\$75~~ \$150; and
- 325.20 (17) pharmacy professional corporation, ~~\$100~~ \$150.
- 325.21 Sec. 26. Minnesota Statutes 2022, section 151.065, subdivision 4, is amended to read:
- 325.22 Subd. 4. **Miscellaneous fees.** Fees for issuance of affidavits and duplicate licenses and
- 325.23 certificates are as follows:
- 325.24 (1) intern affidavit, ~~\$20~~ \$30;
- 325.25 (2) duplicate small license, ~~\$20~~ \$30; and
- 325.26 (3) duplicate large certificate, \$30.

326.1 Sec. 27. Minnesota Statutes 2022, section 151.065, subdivision 6, is amended to read:

326.2 Subd. 6. **Reinstatement fees.** (a) A pharmacist who has allowed the pharmacist's license  
326.3 to lapse may reinstate the license with board approval and upon payment of any fees and  
326.4 late fees in arrears, up to a maximum of \$1,000.

326.5 (b) A pharmacy technician who has allowed the technician's registration to lapse may  
326.6 reinstate the registration with board approval and upon payment of any fees and late fees  
326.7 in arrears, up to a maximum of ~~\$90~~ \$250.

326.8 (c) An owner of a pharmacy, a drug wholesaler, a drug manufacturer, third-party logistics  
326.9 provider, or a medical gas dispenser who has allowed the license of the establishment to  
326.10 lapse may reinstate the license with board approval and upon payment of any fees and late  
326.11 fees in arrears.

326.12 (d) A controlled substance researcher who has allowed the researcher's registration to  
326.13 lapse may reinstate the registration with board approval and upon payment of any fees and  
326.14 late fees in arrears.

326.15 (e) A pharmacist owner of a professional corporation who has allowed the corporation's  
326.16 registration to lapse may reinstate the registration with board approval and upon payment  
326.17 of any fees and late fees in arrears.

326.18 Sec. 28. Minnesota Statutes 2022, section 151.555, is amended to read:

326.19 **151.555 ~~PRESCRIPTION DRUG~~ MEDICATION REPOSITORY PROGRAM.**

326.20 Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in this  
326.21 subdivision have the meanings given.

326.22 (b) "Central repository" means a wholesale distributor that meets the requirements under  
326.23 subdivision 3 and enters into a contract with the Board of Pharmacy in accordance with this  
326.24 section.

326.25 (c) "Distribute" means to deliver, other than by administering or dispensing.

326.26 (d) "Donor" means:

326.27 (1) a health care facility as defined in this subdivision;

326.28 (2) a skilled nursing facility licensed under chapter 144A;

326.29 (3) an assisted living facility licensed under chapter 144G;

326.30 (4) a pharmacy licensed under section 151.19, and located either in the state or outside  
326.31 the state;

- 327.1 (5) a drug wholesaler licensed under section 151.47;
- 327.2 (6) a drug manufacturer licensed under section 151.252; or
- 327.3 (7) an individual at least 18 years of age, provided that the drug or medical supply that  
327.4 is donated was obtained legally and meets the requirements of this section for donation.
- 327.5 (e) "Drug" means any prescription drug that has been approved for medical use in the  
327.6 United States, is listed in the United States Pharmacopoeia or National Formulary, and  
327.7 meets the criteria established under this section for donation; or any over-the-counter  
327.8 medication that meets the criteria established under this section for donation. This definition  
327.9 includes cancer drugs and antirejection drugs, but does not include controlled substances,  
327.10 as defined in section 152.01, subdivision 4, or a prescription drug that can only be dispensed  
327.11 to a patient registered with the drug's manufacturer in accordance with federal Food and  
327.12 Drug Administration requirements.
- 327.13 (f) "Health care facility" means:
- 327.14 (1) a physician's office or health care clinic where licensed practitioners provide health  
327.15 care to patients;
- 327.16 (2) a hospital licensed under section 144.50;
- 327.17 (3) a pharmacy licensed under section 151.19 and located in Minnesota; or
- 327.18 (4) a nonprofit community clinic, including a federally qualified health center; a rural  
327.19 health clinic; public health clinic; or other community clinic that provides health care utilizing  
327.20 a sliding fee scale to patients who are low-income, uninsured, or underinsured.
- 327.21 (g) "Local repository" means a health care facility that elects to accept donated drugs  
327.22 and medical supplies and meets the requirements of subdivision 4.
- 327.23 (h) "Medical supplies" or "supplies" means any prescription ~~and~~ or nonprescription  
327.24 medical supplies needed to administer a ~~prescription~~ drug.
- 327.25 (i) "Original, sealed, unopened, tamper-evident packaging" means packaging that is  
327.26 sealed, unopened, and tamper-evident, including a manufacturer's original unit dose or  
327.27 unit-of-use container, a repackager's original unit dose or unit-of-use container, or unit-dose  
327.28 packaging prepared by a licensed pharmacy according to the standards of Minnesota Rules,  
327.29 part 6800.3750.
- 327.30 (j) "Practitioner" has the meaning given in section 151.01, subdivision 23, except that  
327.31 it does not include a veterinarian.

328.1 Subd. 2. **Establishment; contract and oversight.** ~~By January 1, 2020,~~ (a) The Board  
328.2 of Pharmacy shall establish a ~~drug~~ medication repository program, through which donors  
328.3 may donate a drug or medical supply for use by an individual who meets the eligibility  
328.4 criteria specified under subdivision 5.

328.5 (b) The board shall contract with a central repository that meets the requirements of  
328.6 subdivision 3 to implement and administer the ~~prescription drug~~ medication repository  
328.7 program. The contract must:

328.8 (1) require the board to transfer to the central repository any money appropriated by the  
328.9 legislature for the purpose of operating the medication repository program and require the  
328.10 central repository to spend any money transferred only for purposes specified in the contract;

328.11 (2) require the central repository to report the following performance measures to the  
328.12 board:

328.13 (i) the number of individuals served and the types of medications these individuals  
328.14 received;

328.15 (ii) the number of clinics, pharmacies, and long-term care facilities with which the central  
328.16 repository partnered;

328.17 (iii) the number and cost of medications accepted for inventory, disposed of, and  
328.18 dispensed to individuals in need; and

328.19 (iv) locations within the state to which medications were shipped or delivered; and

328.20 (3) require the board to annually audit the expenditure by the central repository of any  
328.21 money appropriated by the legislature and transferred by the board to ensure that this money  
328.22 is used only for purposes specified in the contract.

328.23 Subd. 3. **Central repository requirements.** (a) The board may publish a request for  
328.24 proposal for participants who meet the requirements of this subdivision and are interested  
328.25 in acting as the central repository for the ~~drug~~ medication repository program. If the board  
328.26 publishes a request for proposal, it shall follow all applicable state procurement procedures  
328.27 in the selection process. The board may also work directly with the University of Minnesota  
328.28 to establish a central repository.

328.29 (b) To be eligible to act as the central repository, the participant must be a wholesale  
328.30 drug distributor located in Minnesota, licensed pursuant to section 151.47, and in compliance  
328.31 with all applicable federal and state statutes, rules, and regulations.

329.1 (c) The central repository shall be subject to inspection by the board pursuant to section  
329.2 151.06, subdivision 1.

329.3 (d) The central repository shall comply with all applicable federal and state laws, rules,  
329.4 and regulations pertaining to the ~~drug~~ medication repository program, drug storage, and  
329.5 dispensing. The facility must maintain in good standing any state license or registration that  
329.6 applies to the facility.

329.7 Subd. 4. **Local repository requirements.** (a) To be eligible for participation in the ~~drug~~  
329.8 medication repository program, a health care facility must agree to comply with all applicable  
329.9 federal and state laws, rules, and regulations pertaining to the ~~drug~~ medication repository  
329.10 program, drug storage, and dispensing. The facility must also agree to maintain in good  
329.11 standing any required state license or registration that may apply to the facility.

329.12 (b) A local repository may elect to participate in the program by submitting the following  
329.13 information to the central repository on a form developed by the board and made available  
329.14 on the board's website:

329.15 (1) the name, street address, and telephone number of the health care facility and any  
329.16 state-issued license or registration number issued to the facility, including the issuing state  
329.17 agency;

329.18 (2) the name and telephone number of a responsible pharmacist or practitioner who is  
329.19 employed by or under contract with the health care facility; and

329.20 (3) a statement signed and dated by the responsible pharmacist or practitioner indicating  
329.21 that the health care facility meets the eligibility requirements under this section and agrees  
329.22 to comply with this section.

329.23 (c) Participation in the ~~drug~~ medication repository program is voluntary. A local  
329.24 repository may withdraw from participation in the ~~drug~~ medication repository program at  
329.25 any time by providing written notice to the central repository on a form developed by the  
329.26 board and made available on the board's website. The central repository shall provide the  
329.27 board with a copy of the withdrawal notice within ten business days from the date of receipt  
329.28 of the withdrawal notice.

329.29 Subd. 5. **Individual eligibility and application requirements.** (a) To be eligible for  
329.30 the ~~drug~~ medication repository program, an individual must submit to a local repository an  
329.31 intake application form that is signed by the individual and attests that the individual:

329.32 (1) is a resident of Minnesota;

330.1 (2) is uninsured and is not enrolled in the medical assistance program under chapter  
330.2 256B or the MinnesotaCare program under chapter 256L, has no prescription drug coverage,  
330.3 or is underinsured;

330.4 (3) acknowledges that the drugs or medical supplies to be received through the program  
330.5 may have been donated; and

330.6 (4) consents to a waiver of the child-resistant packaging requirements of the federal  
330.7 Poison Prevention Packaging Act.

330.8 (b) Upon determining that an individual is eligible for the program, the local repository  
330.9 shall furnish the individual with an identification card. The card shall be valid for one year  
330.10 from the date of issuance and may be used at any local repository. A new identification card  
330.11 may be issued upon expiration once the individual submits a new application form.

330.12 (c) The local repository shall send a copy of the intake application form to the central  
330.13 repository by regular mail, facsimile, or secured email within ten days from the date the  
330.14 application is approved by the local repository.

330.15 (d) The board shall develop and make available on the board's website an application  
330.16 form and the format for the identification card.

330.17 **Subd. 6. Standards and procedures for accepting donations of drugs and supplies. (a)**  
330.18 A donor may donate ~~prescription~~ drugs or medical supplies to the central repository or a  
330.19 local repository if the drug or supply meets the requirements of this section as determined  
330.20 by a pharmacist or practitioner who is employed by or under contract with the central  
330.21 repository or a local repository.

330.22 (b) A ~~prescription~~ drug is eligible for donation under the ~~drug~~ medication repository  
330.23 program if the following requirements are met:

330.24 (1) the donation is accompanied by a ~~drug~~ medication repository donor form described  
330.25 under paragraph (d) that is signed by an individual who is authorized by the donor to attest  
330.26 to the donor's knowledge in accordance with paragraph (d);

330.27 (2) the drug's expiration date is at least six months after the date the drug was donated.  
330.28 If a donated drug bears an expiration date that is less than six months from the donation  
330.29 date, the drug may be accepted and distributed if the drug is in high demand and can be  
330.30 dispensed for use by a patient before the drug's expiration date;

330.31 (3) the drug is in its original, sealed, unopened, tamper-evident packaging that includes  
330.32 the expiration date. Single-unit-dose drugs may be accepted if the single-unit-dose packaging  
330.33 is unopened;

331.1 (4) the drug or the packaging does not have any physical signs of tampering, misbranding,  
331.2 deterioration, compromised integrity, or adulteration;

331.3 (5) the drug does not require storage temperatures other than normal room temperature  
331.4 as specified by the manufacturer or United States Pharmacopoeia, unless the drug is being  
331.5 donated directly by its manufacturer, a wholesale drug distributor, or a pharmacy located  
331.6 in Minnesota; and

331.7 (6) the ~~prescription~~ drug is not a controlled substance.

331.8 (c) A medical supply is eligible for donation under the ~~drug~~ medication repository  
331.9 program if the following requirements are met:

331.10 (1) the supply has no physical signs of tampering, misbranding, or alteration and there  
331.11 is no reason to believe it has been adulterated, tampered with, or misbranded;

331.12 (2) the supply is in its original, unopened, sealed packaging;

331.13 (3) the donation is accompanied by a ~~drug~~ medication repository donor form described  
331.14 under paragraph (d) that is signed by an individual who is authorized by the donor to attest  
331.15 to the donor's knowledge in accordance with paragraph (d); and

331.16 (4) if the supply bears an expiration date, the date is at least six months later than the  
331.17 date the supply was donated. If the donated supply bears an expiration date that is less than  
331.18 six months from the date the supply was donated, the supply may be accepted and distributed  
331.19 if the supply is in high demand and can be dispensed for use by a patient before the supply's  
331.20 expiration date.

331.21 (d) The board shall develop the ~~drug~~ medication repository donor form and make it  
331.22 available on the board's website. The form must state that to the best of the donor's knowledge  
331.23 the donated drug or supply has been properly stored under appropriate temperature and  
331.24 humidity conditions and that the drug or supply has never been opened, used, tampered  
331.25 with, adulterated, or misbranded.

331.26 (e) Donated drugs and supplies may be shipped or delivered to the premises of the central  
331.27 repository or a local repository, and shall be inspected by a pharmacist or an authorized  
331.28 practitioner who is employed by or under contract with the repository and who has been  
331.29 designated by the repository to accept donations. A drop box must not be used to deliver  
331.30 or accept donations.

331.31 (f) The central repository and local repository shall inventory all drugs and supplies  
331.32 donated to the repository. For each drug, the inventory must include the drug's name, strength,  
331.33 quantity, manufacturer, expiration date, and the date the drug was donated. For each medical

332.1 supply, the inventory must include a description of the supply, its manufacturer, the date  
332.2 the supply was donated, and, if applicable, the supply's brand name and expiration date.

332.3 **Subd. 7. Standards and procedures for inspecting and storing donated ~~prescription~~**  
332.4 **drugs and supplies.** (a) A pharmacist or authorized practitioner who is employed by or  
332.5 under contract with the central repository or a local repository shall inspect all donated  
332.6 ~~prescription~~ drugs and supplies before the drug or supply is dispensed to determine, to the  
332.7 extent reasonably possible in the professional judgment of the pharmacist or practitioner,  
332.8 that the drug or supply is not adulterated or misbranded, has not been tampered with, is safe  
332.9 and suitable for dispensing, has not been subject to a recall, and meets the requirements for  
332.10 donation. The pharmacist or practitioner who inspects the drugs or supplies shall sign an  
332.11 inspection record stating that the requirements for donation have been met. If a local  
332.12 repository receives drugs and supplies from the central repository, the local repository does  
332.13 not need to reinspect the drugs and supplies.

332.14 (b) The central repository and local repositories shall store donated drugs and supplies  
332.15 in a secure storage area under environmental conditions appropriate for the drug or supply  
332.16 being stored. Donated drugs and supplies may not be stored with nondonated inventory.

332.17 (c) The central repository and local repositories shall dispose of all ~~prescription~~ drugs  
332.18 and medical supplies that are not suitable for donation in compliance with applicable federal  
332.19 and state statutes, regulations, and rules concerning hazardous waste.

332.20 (d) In the event that controlled substances or ~~prescription~~ drugs that can only be dispensed  
332.21 to a patient registered with the drug's manufacturer are shipped or delivered to a central or  
332.22 local repository for donation, the shipment delivery must be documented by the repository  
332.23 and returned immediately to the donor or the donor's representative that provided the drugs.

332.24 (e) Each repository must develop drug and medical supply recall policies and procedures.  
332.25 If a repository receives a recall notification, the repository shall destroy all of the drug or  
332.26 medical supply in its inventory that is the subject of the recall and complete a record of  
332.27 destruction form in accordance with paragraph (f). If a drug or medical supply that is the  
332.28 subject of a Class I or Class II recall has been dispensed, the repository shall immediately  
332.29 notify the recipient of the recalled drug or medical supply. A drug that potentially is subject  
332.30 to a recall need not be destroyed if its packaging bears a lot number and that lot of the drug  
332.31 is not subject to the recall. If no lot number is on the drug's packaging, it must be destroyed.

332.32 (f) A record of destruction of donated drugs and supplies that are not dispensed under  
332.33 subdivision 8, are subject to a recall under paragraph (e), or are not suitable for donation

333.1 shall be maintained by the repository for at least two years. For each drug or supply destroyed,  
333.2 the record shall include the following information:

333.3 (1) the date of destruction;

333.4 (2) the name, strength, and quantity of the drug destroyed; and

333.5 (3) the name of the person or firm that destroyed the drug.

333.6 Subd. 8. **Dispensing requirements.** (a) Donated drugs and supplies may be dispensed  
333.7 if the drugs or supplies are prescribed by a practitioner for use by an eligible individual and  
333.8 are dispensed by a pharmacist or practitioner. A repository shall dispense drugs and supplies  
333.9 to eligible individuals in the following priority order: (1) individuals who are uninsured;  
333.10 (2) individuals with no prescription drug coverage; and (3) individuals who are underinsured.  
333.11 A repository shall dispense donated ~~prescription~~ drugs in compliance with applicable federal  
333.12 and state laws and regulations for dispensing ~~prescription~~ drugs, including all requirements  
333.13 relating to packaging, labeling, record keeping, drug utilization review, and patient  
333.14 counseling.

333.15 (b) Before dispensing or administering a drug or supply, the pharmacist or practitioner  
333.16 shall visually inspect the drug or supply for adulteration, misbranding, tampering, and date  
333.17 of expiration. Drugs or supplies that have expired or appear upon visual inspection to be  
333.18 adulterated, misbranded, or tampered with in any way must not be dispensed or administered.

333.19 (c) Before a drug or supply is dispensed or administered to an individual, the individual  
333.20 must sign a drug repository recipient form acknowledging that the individual understands  
333.21 the information stated on the form. The board shall develop the form and make it available  
333.22 on the board's website. The form must include the following information:

333.23 (1) that the drug or supply being dispensed or administered has been donated and may  
333.24 have been previously dispensed;

333.25 (2) that a visual inspection has been conducted by the pharmacist or practitioner to ensure  
333.26 that the drug or supply has not expired, has not been adulterated or misbranded, and is in  
333.27 its original, unopened packaging; and

333.28 (3) that the dispensing pharmacist, the dispensing or administering practitioner, the  
333.29 central repository or local repository, the Board of Pharmacy, and any other participant of  
333.30 the ~~drug~~ medication repository program cannot guarantee the safety of the drug or medical  
333.31 supply being dispensed or administered and that the pharmacist or practitioner has determined  
333.32 that the drug or supply is safe to dispense or administer based on the accuracy of the donor's

334.1 form submitted with the donated drug or medical supply and the visual inspection required  
334.2 to be performed by the pharmacist or practitioner before dispensing or administering.

334.3 **Subd. 9. Handling fees.** (a) The central or local repository may charge the individual  
334.4 receiving a drug or supply a handling fee of no more than 250 percent of the medical  
334.5 assistance program dispensing fee for each drug or medical supply dispensed or administered  
334.6 by that repository.

334.7 (b) A repository that dispenses or administers a drug or medical supply through the ~~drug~~  
334.8 medication repository program shall not receive reimbursement under the medical assistance  
334.9 program or the MinnesotaCare program for that dispensed or administered drug or supply.

334.10 **Subd. 10. Distribution of donated drugs and supplies.** (a) The central repository and  
334.11 local repositories may distribute drugs and supplies donated under the ~~drug~~ medication  
334.12 repository program to other participating repositories for use pursuant to this program.

334.13 (b) A local repository that elects not to dispense donated drugs or supplies must transfer  
334.14 all donated drugs and supplies to the central repository. A copy of the donor form that was  
334.15 completed by the original donor under subdivision 6 must be provided to the central  
334.16 repository at the time of transfer.

334.17 **Subd. 11. Forms and record-keeping requirements.** (a) The following forms developed  
334.18 for the administration of this program shall be utilized by the participants of the program  
334.19 and shall be available on the board's website:

334.20 (1) intake application form described under subdivision 5;

334.21 (2) local repository participation form described under subdivision 4;

334.22 (3) local repository withdrawal form described under subdivision 4;

334.23 (4) ~~drug~~ medication repository donor form described under subdivision 6;

334.24 (5) record of destruction form described under subdivision 7; and

334.25 (6) ~~drug~~ medication repository recipient form described under subdivision 8.

334.26 (b) All records, including drug inventory, inspection, and disposal of donated ~~prescription~~  
334.27 drugs and medical supplies, must be maintained by a repository for a minimum of two years.  
334.28 Records required as part of this program must be maintained pursuant to all applicable  
334.29 practice acts.

334.30 (c) Data collected by the ~~drug~~ medication repository program from all local repositories  
334.31 shall be submitted quarterly or upon request to the central repository. Data collected may  
334.32 consist of the information, records, and forms required to be collected under this section.

335.1 (d) The central repository shall submit reports to the board as required by the contract  
335.2 or upon request of the board.

335.3 Subd. 12. **Liability.** (a) The manufacturer of a drug or supply is not subject to criminal  
335.4 or civil liability for injury, death, or loss to a person or to property for causes of action  
335.5 described in clauses (1) and (2). A manufacturer is not liable for:

335.6 (1) the intentional or unintentional alteration of the drug or supply by a party not under  
335.7 the control of the manufacturer; or

335.8 (2) the failure of a party not under the control of the manufacturer to transfer or  
335.9 communicate product or consumer information or the expiration date of the donated drug  
335.10 or supply.

335.11 (b) A health care facility participating in the program, a pharmacist dispensing a drug  
335.12 or supply pursuant to the program, a practitioner dispensing or administering a drug or  
335.13 supply pursuant to the program, or a donor of a drug or medical supply is immune from  
335.14 civil liability for an act or omission that causes injury to or the death of an individual to  
335.15 whom the drug or supply is dispensed and no disciplinary action by a health-related licensing  
335.16 board shall be taken against a pharmacist or practitioner so long as the drug or supply is  
335.17 donated, accepted, distributed, and dispensed according to the requirements of this section.  
335.18 This immunity does not apply if the act or omission involves reckless, wanton, or intentional  
335.19 misconduct, or malpractice unrelated to the quality of the drug or medical supply.

335.20 Subd. 13. **Drug returned for credit.** Nothing in this section allows a long-term care  
335.21 facility to donate a drug to a central or local repository when federal or state law requires  
335.22 the drug to be returned to the pharmacy that initially dispensed it, so that the pharmacy can  
335.23 credit the payer for the amount of the drug returned.

335.24 Subd. 14. **Cooperation.** The central repository, as approved by the Board of Pharmacy,  
335.25 may enter into an agreement with another state that has an established drug repository or  
335.26 drug donation program if the other state's program includes regulations to ensure the purity,  
335.27 integrity, and safety of the drugs and supplies donated, to permit the central repository to  
335.28 offer to another state program inventory that is not needed by a Minnesota resident and to  
335.29 accept inventory from another state program to be distributed to local repositories and  
335.30 dispensed to Minnesota residents in accordance with this program.

335.31 Subd. 15. **Funding.** The central repository may seek grants and other funds from nonprofit  
335.32 charitable organizations, the federal government, and other sources to fund the ongoing  
335.33 operations of the medication repository program.

336.1 Sec. 29. REPEALER.

336.2 Minnesota Rules, parts 5610.0100; 5610.0200; and 5610.0300, are repealed.

336.3

## ARTICLE 6

336.4

### BACKGROUND STUDIES

336.5 Section 1. Minnesota Statutes 2022, section 13.46, subdivision 4, is amended to read:

336.6 Subd. 4. **Licensing data.** (a) As used in this subdivision:

336.7 (1) "licensing data" are all data collected, maintained, used, or disseminated by the  
336.8 welfare system pertaining to persons licensed or registered or who apply for licensure or  
336.9 registration or who formerly were licensed or registered under the authority of the  
336.10 commissioner of human services;

336.11 (2) "client" means a person who is receiving services from a licensee or from an applicant  
336.12 for licensure; and

336.13 (3) "personal and personal financial data" are Social Security numbers, identity of and  
336.14 letters of reference, insurance information, reports from the Bureau of Criminal  
336.15 Apprehension, health examination reports, and social/home studies.

336.16 (b)(1)(i) Except as provided in paragraph (c), the following data on applicants, license  
336.17 holders, and former licensees are public: name, address, telephone number of licensees,  
336.18 date of receipt of a completed application, dates of licensure, licensed capacity, type of  
336.19 client preferred, variances granted, record of training and education in child care and child  
336.20 development, type of dwelling, name and relationship of other family members, previous  
336.21 license history, class of license, the existence and status of complaints, and the number of  
336.22 serious injuries to or deaths of individuals in the licensed program as reported to the  
336.23 commissioner of human services, the local social services agency, or any other county  
336.24 welfare agency. For purposes of this clause, a serious injury is one that is treated by a  
336.25 physician.

336.26 (ii) Except as provided in item (v), when a correction order, an order to forfeit a fine,  
336.27 an order of license suspension, an order of temporary immediate suspension, an order of  
336.28 license revocation, an order of license denial, or an order of conditional license has been  
336.29 issued, or a complaint is resolved, the following data on current and former licensees and  
336.30 applicants are public: the general nature of the complaint or allegations leading to the  
336.31 temporary immediate suspension; the substance and investigative findings of the licensing  
336.32 or maltreatment complaint, licensing violation, or substantiated maltreatment; the existence

337.1 of settlement negotiations; the record of informal resolution of a licensing violation; orders  
337.2 of hearing; findings of fact; conclusions of law; specifications of the final correction order,  
337.3 fine, suspension, temporary immediate suspension, revocation, denial, or conditional license  
337.4 contained in the record of licensing action; whether a fine has been paid; and the status of  
337.5 any appeal of these actions.

337.6 (iii) When a license denial under section 245A.05 or a sanction under section 245A.07  
337.7 is based on a determination that a license holder, applicant, or controlling individual is  
337.8 responsible for maltreatment under section 626.557 or chapter 260E, the identity of the  
337.9 applicant, license holder, or controlling individual as the individual responsible for  
337.10 maltreatment is public data at the time of the issuance of the license denial or sanction.

337.11 (iv) When a license denial under section 245A.05 or a sanction under section 245A.07  
337.12 is based on a determination that a license holder, applicant, or controlling individual is  
337.13 disqualified under chapter 245C, the identity of the license holder, applicant, or controlling  
337.14 individual as the disqualified individual ~~and the reason for the disqualification are~~ is public  
337.15 data at the time of the issuance of the licensing sanction or denial. If the applicant, license  
337.16 holder, or controlling individual requests reconsideration of the disqualification and the  
337.17 disqualification is affirmed, the reason for the disqualification and the reason to not set aside  
337.18 the disqualification are ~~public~~ private data.

337.19 (v) A correction order or fine issued to a child care provider for a licensing violation is  
337.20 private data on individuals under section 13.02, subdivision 12, or nonpublic data under  
337.21 section 13.02, subdivision 9, if the correction order or fine is seven years old or older.

337.22 (2) For applicants who withdraw their application prior to licensure or denial of a license,  
337.23 the following data are public: the name of the applicant, the city and county in which the  
337.24 applicant was seeking licensure, the dates of the commissioner's receipt of the initial  
337.25 application and completed application, the type of license sought, and the date of withdrawal  
337.26 of the application.

337.27 (3) For applicants who are denied a license, the following data are public: the name and  
337.28 address of the applicant, the city and county in which the applicant was seeking licensure,  
337.29 the dates of the commissioner's receipt of the initial application and completed application,  
337.30 the type of license sought, the date of denial of the application, the nature of the basis for  
337.31 the denial, the existence of settlement negotiations, the record of informal resolution of a  
337.32 denial, orders of hearings, findings of fact, conclusions of law, specifications of the final  
337.33 order of denial, and the status of any appeal of the denial.

338.1 (4) When maltreatment is substantiated under section 626.557 or chapter 260E and the  
338.2 victim and the substantiated perpetrator are affiliated with a program licensed under chapter  
338.3 245A, the commissioner of human services, local social services agency, or county welfare  
338.4 agency may inform the license holder where the maltreatment occurred of the identity of  
338.5 the substantiated perpetrator and the victim.

338.6 (5) Notwithstanding clause (1), for child foster care, only the name of the license holder  
338.7 and the status of the license are public if the county attorney has requested that data otherwise  
338.8 classified as public data under clause (1) be considered private data based on the best interests  
338.9 of a child in placement in a licensed program.

338.10 (c) The following are private data on individuals under section 13.02, subdivision 12,  
338.11 or nonpublic data under section 13.02, subdivision 9: personal and personal financial data  
338.12 on family day care program and family foster care program applicants and licensees and  
338.13 their family members who provide services under the license.

338.14 (d) The following are private data on individuals: the identity of persons who have made  
338.15 reports concerning licensees or applicants that appear in inactive investigative data, and the  
338.16 records of clients or employees of the licensee or applicant for licensure whose records are  
338.17 received by the licensing agency for purposes of review or in anticipation of a contested  
338.18 matter. The names of reporters of complaints or alleged violations of licensing standards  
338.19 under chapters 245A, 245B, 245C, and 245D, and applicable rules and alleged maltreatment  
338.20 under section 626.557 and chapter 260E, are confidential data and may be disclosed only  
338.21 as provided in section 260E.21, subdivision 4; 260E.35; or 626.557, subdivision 12b.

338.22 (e) Data classified as private, confidential, nonpublic, or protected nonpublic under this  
338.23 subdivision become public data if submitted to a court or administrative law judge as part  
338.24 of a disciplinary proceeding in which there is a public hearing concerning a license which  
338.25 has been suspended, immediately suspended, revoked, or denied.

338.26 (f) Data generated in the course of licensing investigations that relate to an alleged  
338.27 violation of law are investigative data under subdivision 3.

338.28 (g) Data that are not public data collected, maintained, used, or disseminated under this  
338.29 subdivision that relate to or are derived from a report as defined in section 260E.03, or  
338.30 626.5572, subdivision 18, are subject to the destruction provisions of sections 260E.35,  
338.31 subdivision 6, and 626.557, subdivision 12b.

338.32 (h) Upon request, not public data collected, maintained, used, or disseminated under  
338.33 this subdivision that relate to or are derived from a report of substantiated maltreatment as  
338.34 defined in section 626.557 or chapter 260E may be exchanged with the Department of

339.1 Health for purposes of completing background studies pursuant to section 144.057 and with  
339.2 the Department of Corrections for purposes of completing background studies pursuant to  
339.3 section 241.021.

339.4 (i) Data on individuals collected according to licensing activities under chapters 245A  
339.5 and 245C, data on individuals collected by the commissioner of human services according  
339.6 to investigations under section 626.557 and chapters 245A, 245B, 245C, 245D, and 260E  
339.7 may be shared with the Department of Human Rights, the Department of Health, the  
339.8 Department of Corrections, the ombudsman for mental health and developmental disabilities,  
339.9 and the individual's professional regulatory board when there is reason to believe that laws  
339.10 or standards under the jurisdiction of those agencies may have been violated or the  
339.11 information may otherwise be relevant to the board's regulatory jurisdiction. Background  
339.12 study data on an individual who is the subject of a background study under chapter 245C  
339.13 for a licensed service for which the commissioner of human services is the license holder  
339.14 may be shared with the commissioner and the commissioner's delegate by the licensing  
339.15 division. Unless otherwise specified in this chapter, the identity of a reporter of alleged  
339.16 maltreatment or licensing violations may not be disclosed.

339.17 (j) In addition to the notice of determinations required under sections 260E.24,  
339.18 subdivisions 5 and 7, and 260E.30, subdivision 6, paragraphs (b), (c), (d), (e), and (f), if the  
339.19 commissioner or the local social services agency has determined that an individual is a  
339.20 substantiated perpetrator of maltreatment of a child based on sexual abuse, as defined in  
339.21 section 260E.03, and the commissioner or local social services agency knows that the  
339.22 individual is a person responsible for a child's care in another facility, the commissioner or  
339.23 local social services agency shall notify the head of that facility of this determination. The  
339.24 notification must include an explanation of the individual's available appeal rights and the  
339.25 status of any appeal. If a notice is given under this paragraph, the government entity making  
339.26 the notification shall provide a copy of the notice to the individual who is the subject of the  
339.27 notice.

339.28 (k) All not public data collected, maintained, used, or disseminated under this subdivision  
339.29 and subdivision 3 may be exchanged between the Department of Human Services, Licensing  
339.30 Division, and the Department of Corrections for purposes of regulating services for which  
339.31 the Department of Human Services and the Department of Corrections have regulatory  
339.32 authority.

340.1 Sec. 2. Minnesota Statutes 2022, section 245C.02, is amended by adding a subdivision to  
340.2 read:

340.3 Subd. 7a. **Conservator.** "Conservator" has the meaning given under section 524.1-201,  
340.4 clause (10), and includes proposed and current conservators.

340.5 Sec. 3. Minnesota Statutes 2022, section 245C.02, is amended by adding a subdivision to  
340.6 read:

340.7 Subd. 11f. **Guardian.** "Guardian" has the meaning given under section 524.1-201, clause  
340.8 (27), and includes proposed and current guardians.

340.9 Sec. 4. Minnesota Statutes 2022, section 245C.02, subdivision 13e, is amended to read:

340.10 Subd. 13e. **NETStudy 2.0.** "NETStudy 2.0" means the commissioner's system that  
340.11 replaces both NETStudy and the department's internal background study processing system.  
340.12 NETStudy 2.0 is designed to enhance protection of children and vulnerable adults by  
340.13 improving the accuracy of background studies through fingerprint-based criminal record  
340.14 checks and expanding the background studies to include a review of information from the  
340.15 Minnesota Court Information System and the national crime information database. NETStudy  
340.16 2.0 is also designed to increase efficiencies in and the speed of the hiring process by:

340.17 (1) providing access to and updates from public web-based data related to employment  
340.18 eligibility;

340.19 (2) decreasing the need for repeat studies through electronic updates of background  
340.20 study subjects' criminal records;

340.21 (3) supporting identity verification using subjects' Social Security numbers and  
340.22 photographs;

340.23 (4) using electronic employer notifications; ~~and~~

340.24 (5) issuing immediate verification of subjects' eligibility to provide services as more  
340.25 studies are completed under the NETStudy 2.0 system; and

340.26 (6) providing electronic access to certain notices for entities and background study  
340.27 subjects.

340.28 Sec. 5. Minnesota Statutes 2022, section 245C.03, subdivision 1, is amended to read:

340.29 Subdivision 1. **Licensed programs.** (a) The commissioner shall conduct a background  
340.30 study on:

- 341.1 (1) the person or persons applying for a license;
- 341.2 (2) an individual age 13 and over living in the household where the licensed program  
341.3 will be provided who is not receiving licensed services from the program;
- 341.4 (3) current or prospective employees or contractors of the applicant who will have direct  
341.5 contact with persons served by the facility, agency, or program;
- 341.6 (4) volunteers or student volunteers who will have direct contact with persons served  
341.7 by the program to provide program services if the contact is not under the continuous, direct  
341.8 supervision by an individual listed in clause (1) or (3);
- 341.9 (5) an individual age ten to 12 living in the household where the licensed services will  
341.10 be provided when the commissioner has reasonable cause as defined in section 245C.02,  
341.11 subdivision 15;
- 341.12 (6) an individual who, without providing direct contact services at a licensed program,  
341.13 may have unsupervised access to children or vulnerable adults receiving services from a  
341.14 program, when the commissioner has reasonable cause as defined in section 245C.02,  
341.15 subdivision 15;
- 341.16 (7) all controlling individuals as defined in section 245A.02, subdivision 5a;
- 341.17 (8) notwithstanding the other requirements in this subdivision, child care background  
341.18 study subjects as defined in section 245C.02, subdivision 6a; and
- 341.19 (9) notwithstanding clause (3), for children's residential facilities and foster residence  
341.20 settings, any adult working in the facility, whether or not the individual will have direct  
341.21 contact with persons served by the facility.
- 341.22 (b) For child foster care when the license holder resides in the home where foster care  
341.23 services are provided, a short-term substitute caregiver providing direct contact services for  
341.24 a child for less than 72 hours of continuous care is not required to receive a background  
341.25 study under this chapter.
- 341.26 (c) This subdivision applies to the following programs that must be licensed under  
341.27 chapter 245A:
- 341.28 (1) adult foster care;
- 341.29 (2) child foster care;
- 341.30 (3) children's residential facilities;
- 341.31 (4) family child care;

- 342.1 (5) licensed child care centers;
- 342.2 (6) licensed home and community-based services under chapter 245D;
- 342.3 (7) residential mental health programs for adults;
- 342.4 (8) substance use disorder treatment programs under chapter 245G;
- 342.5 (9) withdrawal management programs under chapter 245F;
- 342.6 (10) adult day care centers;
- 342.7 (11) family adult day services;
- 342.8 (12) independent living assistance for youth;
- 342.9 (13) detoxification programs;
- 342.10 (14) community residential settings; ~~and~~
- 342.11 (15) intensive residential treatment services and residential crisis stabilization under
- 342.12 chapter 245I; and
- 342.13 (16) treatment programs for persons with sexual psychopathic personality or sexually
- 342.14 dangerous persons, licensed under chapter 245A and according to Minnesota Rules, parts
- 342.15 9515.3000 to 9515.3110.
- 342.16 Sec. 6. Minnesota Statutes 2022, section 245C.03, subdivision 1a, is amended to read:
- 342.17 Subd. 1a. **Procedure.** (a) Individuals and organizations that are required under this
- 342.18 section to have or initiate background studies shall comply with the requirements of this
- 342.19 chapter.
- 342.20 (b) All studies conducted under this section shall be conducted according to sections
- 342.21 299C.60 to 299C.64. This requirement does not apply to subdivisions 1, paragraph (c),
- 342.22 clauses (2) to (5), and 6a.
- 342.23 (c) All data obtained by the commissioner for a background study completed under this
- 342.24 section shall be classified as private data.
- 342.25 Sec. 7. Minnesota Statutes 2022, section 245C.031, subdivision 1, is amended to read:
- 342.26 Subdivision 1. **Alternative background studies.** (a) The commissioner shall conduct
- 342.27 an alternative background study of individuals listed in this section.

343.1 (b) Notwithstanding other sections of this chapter, all alternative background studies  
343.2 except subdivision 12 shall be conducted according to this section and with sections 299C.60  
343.3 to 299C.64.

343.4 (c) All terms in this section shall have the definitions provided in section 245C.02.

343.5 (d) The entity that submits an alternative background study request under this section  
343.6 shall submit the request to the commissioner according to section 245C.05.

343.7 (e) The commissioner shall comply with the destruction requirements in section 245C.051.

343.8 (f) Background studies conducted under this section are subject to the provisions of  
343.9 section 245C.32.

343.10 (g) The commissioner shall forward all information that the commissioner receives under  
343.11 section 245C.08 to the entity that submitted the alternative background study request under  
343.12 subdivision 2. The commissioner shall not make any eligibility determinations regarding  
343.13 background studies conducted under this section.

343.14 (h) All data obtained by the commissioner for a background study completed under this  
343.15 section shall be classified as private data.

343.16 Sec. 8. **[245C.033] GUARDIANS AND CONSERVATORS; MALTREATMENT**  
343.17 **AND STATE LICENSING AGENCY CHECKS.**

343.18 Subdivision 1. Maltreatment data. Requests for maltreatment data and records checks  
343.19 submitted pursuant to section 524.5-118 shall include information regarding whether the  
343.20 guardian or conservator has been a perpetrator of substantiated maltreatment of a vulnerable  
343.21 adult under section 626.557 or a minor under chapter 260E. If the guardian or conservator  
343.22 has been the perpetrator of substantiated maltreatment of a vulnerable adult or a minor, the  
343.23 commissioner must include a copy of any available public portion of the investigation  
343.24 memorandum under section 626.557, subdivision 12b, or any available public portion of  
343.25 the investigation memorandum under section 260E.30.

343.26 Subd. 2. State licensing agency data. (a) Requests for state licensing agency data and  
343.27 records checks submitted pursuant to section 524.5-118 shall include information from a  
343.28 check of state licensing agency records.

343.29 (b) The commissioner shall provide the court with licensing agency data for licenses  
343.30 directly related to the responsibilities of a guardian or conservator if the guardian or  
343.31 conservator has a current or prior affiliation with the:

343.32 (1) Lawyers Responsibility Board;

- 344.1 (2) State Board of Accountancy;
- 344.2 (3) Board of Social Work;
- 344.3 (4) Board of Psychology;
- 344.4 (5) Board of Nursing;
- 344.5 (6) Board of Medical Practice;
- 344.6 (7) Department of Education;
- 344.7 (8) Department of Commerce;
- 344.8 (9) Board of Chiropractic Examiners;
- 344.9 (10) Board of Dentistry;
- 344.10 (11) Board of Marriage and Family Therapy;
- 344.11 (12) Department of Human Services;
- 344.12 (13) Peace Officer Standards and Training (POST) Board; and
- 344.13 (14) Professional Educator Licensing and Standards Board.
- 344.14 (c) The commissioner shall provide to the court the electronically available data
- 344.15 maintained in the agency's database, including whether the guardian or conservator is or
- 344.16 has been licensed by the agency and whether a disciplinary action or a sanction against the
- 344.17 individual's license, including a condition, suspension, revocation, or cancellation, is in the
- 344.18 licensing agency's database.
- 344.19 Subd. 3. **Procedure; maltreatment and state licensing agency data.** Requests for
- 344.20 maltreatment and state licensing agency data checks shall be submitted by the guardian or
- 344.21 conservator to the commissioner on the form or in the manner prescribed by the
- 344.22 commissioner. Upon receipt of a signed informed consent, and payment under 245C.10,
- 344.23 the commissioner shall complete the maltreatment and state licensing agency checks. Upon
- 344.24 completion of the checks, the commissioner shall provide the requested information to the
- 344.25 courts on the form or in the manner prescribed by the commissioner.
- 344.26 Subd. 4. **Classification of maltreatment and state licensing agency data; access to**
- 344.27 **information.** All data obtained by the commissioner for maltreatment and state licensing
- 344.28 agency checks completed under this section shall be classified as private data.

345.1 Sec. 9. Minnesota Statutes 2022, section 245C.05, subdivision 1, is amended to read:

345.2 Subdivision 1. **Individual studied.** (a) The individual who is the subject of the  
345.3 background study must provide the applicant, license holder, or other entity under section  
345.4 245C.04 with sufficient information to ensure an accurate study, including:

345.5 (1) the individual's first, middle, and last name and all other names by which the  
345.6 individual has been known;

345.7 (2) current home address, city, and state of residence;

345.8 (3) current zip code;

345.9 (4) sex;

345.10 (5) date of birth;

345.11 (6) driver's license number or state identification number; and

345.12 (7) upon implementation of NETStudy 2.0, the home address, city, county, and state of  
345.13 residence for the past five years.

345.14 (b) Every subject of a background study conducted or initiated by counties or private  
345.15 agencies under this chapter must also provide the home address, city, county, and state of  
345.16 residence for the past five years.

345.17 (c) Every subject of a background study related to private agency adoptions or related  
345.18 to child foster care licensed through a private agency, who is 18 years of age or older, shall  
345.19 also provide the commissioner a signed consent for the release of any information received  
345.20 from national crime information databases to the private agency that initiated the background  
345.21 study.

345.22 (d) The subject of a background study shall provide fingerprints and a photograph as  
345.23 required in subdivision 5.

345.24 (e) The subject of a background study shall submit a completed criminal and maltreatment  
345.25 history records check consent form for applicable national and state level record checks.

345.26 (f) A background study subject who has access to the NETStudy 2.0 applicant portal  
345.27 must provide updated contact information to the commissioner via NETStudy 2.0 any time  
345.28 their personal information changes for as long as they remain affiliated on any roster.

345.29 (g) An entity must update contact information in NETStudy 2.0 for a background study  
345.30 subject on the entity's roster any time the entity receives new contact information from the  
345.31 study subject.

346.1 Sec. 10. Minnesota Statutes 2022, section 245C.05, subdivision 2c, is amended to read:

346.2 Subd. 2c. **Privacy notice to background study subject.** (a) Prior to initiating each  
346.3 background study, the entity initiating the study must provide the commissioner's privacy  
346.4 notice to the background study subject required under section 13.04, subdivision 2. The  
346.5 notice must be available through the commissioner's electronic NETStudy and NETStudy  
346.6 2.0 systems and shall include the information in paragraphs (b) and (c).

346.7 (b) The background study subject shall be informed that any previous background studies  
346.8 that received a set-aside will be reviewed, and without further contact with the background  
346.9 study subject, the commissioner may notify the agency that initiated the subsequent  
346.10 background study:

346.11 ~~(1) that the individual has a disqualification that has been set aside for the program or~~  
346.12 ~~agency that initiated the study;~~

346.13 ~~(2) the reason for the disqualification; and~~

346.14 ~~(3) that information about the decision to set aside the disqualification will be available~~  
346.15 ~~to the license holder upon request without the consent of the background study subject.~~

346.16 (c) The background study subject must also be informed that:

346.17 (1) the subject's fingerprints collected for purposes of completing the background study  
346.18 under this chapter must not be retained by the Department of Public Safety, Bureau of  
346.19 Criminal Apprehension, or by the commissioner. The Federal Bureau of Investigation will  
346.20 not retain background study subjects' fingerprints;

346.21 (2) effective upon implementation of NETStudy 2.0, the subject's photographic image  
346.22 will be retained by the commissioner, and if the subject has provided the subject's Social  
346.23 Security number for purposes of the background study, the photographic image will be  
346.24 available to prospective employers and agencies initiating background studies under this  
346.25 chapter to verify the identity of the subject of the background study;

346.26 (3) the authorized fingerprint collection vendor or vendors shall, for purposes of verifying  
346.27 the identity of the background study subject, be able to view the identifying information  
346.28 entered into NETStudy 2.0 by the entity that initiated the background study, but shall not  
346.29 retain the subject's fingerprints, photograph, or information from NETStudy 2.0. The  
346.30 authorized fingerprint collection vendor or vendors shall retain no more than the subject's  
346.31 name and the date and time the subject's fingerprints were recorded and sent, only as  
346.32 necessary for auditing and billing activities;

347.1 (4) the commissioner shall provide the subject notice, as required in section 245C.17,  
347.2 subdivision 1, paragraph (a), when an entity initiates a background study on the individual;

347.3 (5) the subject may request in writing a report listing the entities that initiated a  
347.4 background study on the individual as provided in section 245C.17, subdivision 1, paragraph  
347.5 (b);

347.6 (6) the subject may request in writing that information used to complete the individual's  
347.7 background study in NETStudy 2.0 be destroyed if the requirements of section 245C.051,  
347.8 paragraph (a), are met; and

347.9 (7) notwithstanding clause (6), the commissioner shall destroy:

347.10 (i) the subject's photograph after a period of two years when the requirements of section  
347.11 245C.051, paragraph (c), are met; and

347.12 (ii) any data collected on a subject under this chapter after a period of two years following  
347.13 the individual's death as provided in section 245C.051, paragraph (d).

347.14 Sec. 11. Minnesota Statutes 2022, section 245C.05, subdivision 4, is amended to read:

347.15 Subd. 4. **Electronic transmission.** (a) For background studies conducted by the  
347.16 Department of Human Services, the commissioner shall implement a secure system for the  
347.17 electronic transmission of:

347.18 (1) background study information to the commissioner;

347.19 (2) background study results to the license holder;

347.20 (3) background study information obtained under this section and section 245C.08 to  
347.21 counties and private agencies for background studies conducted by the commissioner for  
347.22 child foster care, including a summary of nondisqualifying results, except as prohibited by  
347.23 law; and

347.24 (4) background study results to county agencies for background studies conducted by  
347.25 the commissioner for adult foster care and family adult day services and, upon  
347.26 implementation of NETStudy 2.0, family child care and legal nonlicensed child care  
347.27 authorized under chapter 119B.

347.28 (b) Unless the commissioner has granted a hardship variance under paragraph (c), a  
347.29 license holder or an applicant must use the electronic transmission system known as  
347.30 NETStudy or NETStudy 2.0 to submit all requests for background studies to the  
347.31 commissioner as required by this chapter.

348.1 (c) A license holder or applicant whose program is located in an area in which high-speed  
348.2 Internet is inaccessible may request the commissioner to grant a variance to the electronic  
348.3 transmission requirement.

348.4 (d) Section 245C.08, subdivision 3, paragraph (c), applies to results transmitted under  
348.5 this subdivision.

348.6 (e) The background study subject shall access background study-related documents  
348.7 electronically in the applicant portal. A background study subject may request the  
348.8 commissioner to grant a variance to the requirement to access documents electronically in  
348.9 the NETStudy 2.0 applicant portal, and maintains the ability to request paper documentation  
348.10 of their background studies.

348.11 Sec. 12. Minnesota Statutes 2022, section 245C.08, subdivision 1, is amended to read:

348.12 Subdivision 1. **Background studies conducted by Department of Human Services.** (a)  
348.13 For a background study conducted by the Department of Human Services, the commissioner  
348.14 shall review:

348.15 (1) information related to names of substantiated perpetrators of maltreatment of  
348.16 vulnerable adults that has been received by the commissioner as required under section  
348.17 626.557, subdivision 9c, paragraph (j);

348.18 (2) the commissioner's records relating to the maltreatment of minors in licensed  
348.19 programs, and from findings of maltreatment of minors as indicated through the social  
348.20 service information system;

348.21 (3) information from juvenile courts as required in subdivision 4 for individuals listed  
348.22 in section 245C.03, subdivision 1, paragraph (a), when there is reasonable cause;

348.23 (4) information from the Bureau of Criminal Apprehension, including information  
348.24 regarding a background study subject's registration in Minnesota as a predatory offender  
348.25 under section 243.166;

348.26 (5) except as provided in clause (6), information received as a result of submission of  
348.27 fingerprints for a national criminal history record check, as defined in section 245C.02,  
348.28 subdivision 13c, when the commissioner has reasonable cause for a national criminal history  
348.29 record check as defined under section 245C.02, subdivision 15a, or as required under section  
348.30 144.057, subdivision 1, clause (2);

348.31 (6) for a background study related to a child foster family setting application for licensure,  
348.32 foster residence settings, children's residential facilities, a transfer of permanent legal and

349.1 physical custody of a child under sections 260C.503 to 260C.515, or adoptions, and for a  
349.2 background study required for family child care, certified license-exempt child care, child  
349.3 care centers, and legal nonlicensed child care authorized under chapter 119B, the  
349.4 commissioner shall also review:

349.5 (i) information from the child abuse and neglect registry for any state in which the  
349.6 background study subject has resided for the past five years;

349.7 (ii) when the background study subject is 18 years of age or older, or a minor under  
349.8 section 245C.05, subdivision 5a, paragraph (c), information received following submission  
349.9 of fingerprints for a national criminal history record check; and

349.10 (iii) when the background study subject is 18 years of age or older or a minor under  
349.11 section 245C.05, subdivision 5a, paragraph (d), for licensed family child care, certified  
349.12 license-exempt child care, licensed child care centers, and legal nonlicensed child care  
349.13 authorized under chapter 119B, information obtained using non-fingerprint-based data  
349.14 including information from the criminal and sex offender registries for any state in which  
349.15 the background study subject resided for the past five years and information from the national  
349.16 crime information database and the national sex offender registry; ~~and~~

349.17 (7) for a background study required for family child care, certified license-exempt child  
349.18 care centers, licensed child care centers, and legal nonlicensed child care authorized under  
349.19 chapter 119B, the background study shall also include, to the extent practicable, a name  
349.20 and date-of-birth search of the National Sex Offender Public website; and

349.21 (8) for a background study required for treatment programs for sexual psychopathic  
349.22 personality or sexually dangerous persons, the background study shall only include a review  
349.23 of the information required under paragraph (a), clauses (1), (2), (3), and (4).

349.24 (b) Notwithstanding expungement by a court, the commissioner may consider information  
349.25 obtained under paragraph (a), clauses (3) and (4), unless the commissioner received notice  
349.26 of the petition for expungement and the court order for expungement is directed specifically  
349.27 to the commissioner.

349.28 (c) The commissioner shall also review criminal case information received according  
349.29 to section 245C.04, subdivision 4a, from the Minnesota court information system that relates  
349.30 to individuals who have already been studied under this chapter and who remain affiliated  
349.31 with the agency that initiated the background study.

349.32 (d) When the commissioner has reasonable cause to believe that the identity of a  
349.33 background study subject is uncertain, the commissioner may require the subject to provide

350.1 a set of classifiable fingerprints for purposes of completing a fingerprint-based record check  
350.2 with the Bureau of Criminal Apprehension. Fingerprints collected under this paragraph  
350.3 shall not be saved by the commissioner after they have been used to verify the identity of  
350.4 the background study subject against the particular criminal record in question.

350.5 (e) The commissioner may inform the entity that initiated a background study under  
350.6 NETStudy 2.0 of the status of processing of the subject's fingerprints.

350.7 Sec. 13. Minnesota Statutes 2022, section 245C.10, subdivision 1d, is amended to read:

350.8 Subd. 1d. **State; national criminal history record check fees.** The commissioner may  
350.9 increase background study fees as necessary, commensurate with an increase in state Bureau  
350.10 of Criminal Apprehension or the national criminal history record check fee fees. The  
350.11 commissioner shall report any fee increase under this subdivision to the legislature during  
350.12 the legislative session following the fee increase, so that the legislature may consider adoption  
350.13 of the fee increase into statute. By July 1 of every year, background study fees shall be set  
350.14 at the amount adopted by the legislature under this section.

350.15 Sec. 14. Minnesota Statutes 2022, section 245C.10, subdivision 2, is amended to read:

350.16 Subd. 2. **Supplemental nursing services agencies.** The commissioner shall recover the  
350.17 cost of the background studies initiated by supplemental nursing services agencies registered  
350.18 under section 144A.71, subdivision 1, through a fee of no more than ~~\$42~~ \$44 per study  
350.19 charged to the agency. The fees collected under this subdivision are appropriated to the  
350.20 commissioner for the purpose of conducting background studies.

350.21 Sec. 15. Minnesota Statutes 2022, section 245C.10, subdivision 3, is amended to read:

350.22 Subd. 3. **Personal care provider organizations.** The commissioner shall recover the  
350.23 cost of background studies initiated by a personal care provider organization under sections  
350.24 256B.0651 to 256B.0654 and 256B.0659 through a fee of no more than ~~\$42~~ \$44 per study  
350.25 charged to the organization responsible for submitting the background study form. The fees  
350.26 collected under this subdivision are appropriated to the commissioner for the purpose of  
350.27 conducting background studies.

350.28 Sec. 16. Minnesota Statutes 2022, section 245C.10, subdivision 4, is amended to read:

350.29 Subd. 4. **Temporary personnel agencies, educational programs, and professional**  
350.30 **services agencies.** The commissioner shall recover the cost of the background studies  
350.31 initiated by temporary personnel agencies, educational programs, and professional services

351.1 agencies that initiate background studies under section 245C.03, subdivision 4, through a  
351.2 fee of no more than ~~\$42~~ \$44 per study charged to the agency. The fees collected under this  
351.3 subdivision are appropriated to the commissioner for the purpose of conducting background  
351.4 studies.

351.5 Sec. 17. Minnesota Statutes 2022, section 245C.10, subdivision 5, is amended to read:

351.6 Subd. 5. **Adult foster care and family adult day services.** The commissioner shall  
351.7 recover the cost of background studies required under section 245C.03, subdivision 1, for  
351.8 the purposes of adult foster care and family adult day services licensing, through a fee of  
351.9 no more than ~~\$42~~ \$44 per study charged to the license holder. The fees collected under this  
351.10 subdivision are appropriated to the commissioner for the purpose of conducting background  
351.11 studies.

351.12 Sec. 18. Minnesota Statutes 2022, section 245C.10, subdivision 6, is amended to read:

351.13 Subd. 6. **Unlicensed home and community-based waiver providers of service to**  
351.14 **seniors and individuals with disabilities.** The commissioner shall recover the cost of  
351.15 background studies initiated by unlicensed home and community-based waiver providers  
351.16 of service to seniors and individuals with disabilities under section 256B.4912 through a  
351.17 fee of no more than ~~\$42~~ \$44 per study.

351.18 Sec. 19. Minnesota Statutes 2022, section 245C.10, subdivision 8, is amended to read:

351.19 Subd. 8. **Children's therapeutic services and supports providers.** The commissioner  
351.20 shall recover the cost of background studies required under section 245C.03, subdivision  
351.21 7, for the purposes of children's therapeutic services and supports under section 256B.0943,  
351.22 through a fee of no more than ~~\$42~~ \$44 per study charged to the license holder. The fees  
351.23 collected under this subdivision are appropriated to the commissioner for the purpose of  
351.24 conducting background studies.

351.25 Sec. 20. Minnesota Statutes 2022, section 245C.10, subdivision 9, is amended to read:

351.26 Subd. 9. **Human services licensed programs.** The commissioner shall recover the cost  
351.27 of background studies required under section 245C.03, subdivision 1, for all programs that  
351.28 are licensed by the commissioner, except child foster care when the applicant or license  
351.29 holder resides in the home where child foster care services are provided, family child care,  
351.30 child care centers, certified license-exempt child care centers, and legal nonlicensed child  
351.31 care authorized under chapter 119B, through a fee of no more than ~~\$42~~ \$44 per study charged

352.1 to the license holder. The fees collected under this subdivision are appropriated to the  
352.2 commissioner for the purpose of conducting background studies.

352.3 Sec. 21. Minnesota Statutes 2022, section 245C.10, subdivision 9a, is amended to read:

352.4 Subd. 9a. **Child care programs.** The commissioner shall recover the cost of a background  
352.5 study required for family child care, certified license-exempt child care centers, licensed  
352.6 child care centers, and legal nonlicensed child care providers authorized under chapter 119B  
352.7 through a fee of no more than ~~\$40~~ \$44 per study charged to the license holder. A fee of no  
352.8 more than ~~\$42~~ \$44 per study shall be charged for studies conducted under section 245C.05,  
352.9 subdivision 5a, paragraph (a). The fees collected under this subdivision are appropriated to  
352.10 the commissioner to conduct background studies.

352.11 Sec. 22. Minnesota Statutes 2022, section 245C.10, subdivision 10, is amended to read:

352.12 Subd. 10. **Community first services and supports organizations.** The commissioner  
352.13 shall recover the cost of background studies initiated by an agency-provider delivering  
352.14 services under section 256B.85, subdivision 11, or a financial management services provider  
352.15 providing service functions under section 256B.85, subdivision 13, through a fee of no more  
352.16 than ~~\$42~~ \$44 per study, charged to the organization responsible for submitting the background  
352.17 study form. The fees collected under this subdivision are appropriated to the commissioner  
352.18 for the purpose of conducting background studies.

352.19 Sec. 23. Minnesota Statutes 2022, section 245C.10, subdivision 11, is amended to read:

352.20 Subd. 11. **Providers of housing support.** The commissioner shall recover the cost of  
352.21 background studies initiated by providers of housing support under section 256I.04 through  
352.22 a fee of no more than ~~\$42~~ \$44 per study. The fees collected under this subdivision are  
352.23 appropriated to the commissioner for the purpose of conducting background studies.

352.24 Sec. 24. Minnesota Statutes 2022, section 245C.10, subdivision 12, is amended to read:

352.25 Subd. 12. **Child protection workers or social services staff having responsibility for**  
352.26 **child protective duties.** The commissioner shall recover the cost of background studies  
352.27 initiated by county social services agencies and local welfare agencies for individuals who  
352.28 are required to have a background study under section 260E.36, subdivision 3, through a  
352.29 fee of no more than ~~\$42~~ \$44 per study. The fees collected under this subdivision are  
352.30 appropriated to the commissioner for the purpose of conducting background studies.

353.1 Sec. 25. Minnesota Statutes 2022, section 245C.10, subdivision 13, is amended to read:

353.2 Subd. 13. **Providers of special transportation service.** The commissioner shall recover  
 353.3 the cost of background studies initiated by providers of special transportation service under  
 353.4 section 174.30 through a fee of no more than ~~\$42~~ \$44 per study. The fees collected under  
 353.5 this subdivision are appropriated to the commissioner for the purpose of conducting  
 353.6 background studies.

353.7 Sec. 26. Minnesota Statutes 2022, section 245C.10, subdivision 14, is amended to read:

353.8 Subd. 14. **Children's residential facilities.** The commissioner shall recover the cost of  
 353.9 background studies initiated by a licensed children's residential facility through a fee of no  
 353.10 more than ~~\$51~~ \$53 per study. Fees collected under this subdivision are appropriated to the  
 353.11 commissioner for purposes of conducting background studies.

353.12 Sec. 27. Minnesota Statutes 2022, section 245C.10, subdivision 15, is amended to read:

353.13 Subd. 15. **Guardians and conservators.** The commissioner shall recover the cost of  
 353.14 conducting ~~background studies~~ maltreatment and state licensing agency checks for guardians  
 353.15 and conservators under section ~~524.5-118~~ 245C.033 through a fee of no more than ~~\$110~~  
 353.16 \$50 per study. The fees collected under this subdivision are appropriated to the commissioner  
 353.17 for the purpose of conducting ~~background studies~~ maltreatment and state licensing agency  
 353.18 checks. ~~The fee for conducting an alternative background study for appointment of a~~  
 353.19 ~~professional guardian or conservator must be paid by the guardian or conservator. In other~~  
 353.20 ~~cases, the fee must be paid as follows:~~ must be paid directly to and in the manner prescribed  
 353.21 by the commissioner before any maltreatment and state licensing agency checks under  
 353.22 section 245C.033 may be conducted.

353.23 ~~(1) if the matter is proceeding in forma pauperis, the fee must be paid as an expense for~~  
 353.24 ~~purposes of section 524.5-502, paragraph (a);~~

353.25 ~~(2) if there is an estate of the ward or protected person, the fee must be paid from the~~  
 353.26 ~~estate; or~~

353.27 ~~(3) in the case of a guardianship or conservatorship of a person that is not proceeding~~  
 353.28 ~~in forma pauperis, the fee must be paid by the guardian, conservator, or the court.~~

353.29 Sec. 28. Minnesota Statutes 2022, section 245C.10, subdivision 16, is amended to read:

353.30 Subd. 16. **Providers of housing support services.** The commissioner shall recover the  
 353.31 cost of background studies initiated by providers of housing support services under section

354.1 256B.051 through a fee of no more than ~~\$42~~ \$44 per study. The fees collected under this  
354.2 subdivision are appropriated to the commissioner for the purpose of conducting background  
354.3 studies.

354.4 Sec. 29. Minnesota Statutes 2022, section 245C.10, subdivision 17, is amended to read:

354.5 Subd. 17. **Early intensive developmental and behavioral intervention providers.** The  
354.6 commissioner shall recover the cost of background studies required under section 245C.03,  
354.7 subdivision 15, for the purposes of early intensive developmental and behavioral intervention  
354.8 under section 256B.0949, through a fee of no more than ~~\$42~~ \$44 per study charged to the  
354.9 enrolled agency. The fees collected under this subdivision are appropriated to the  
354.10 commissioner for the purpose of conducting background studies.

354.11 Sec. 30. Minnesota Statutes 2022, section 245C.10, subdivision 20, is amended to read:

354.12 Subd. 20. **Professional Educators Licensing Standards Board.** The commissioner  
354.13 shall recover the cost of background studies initiated by the Professional Educators Licensing  
354.14 Standards Board through a fee of no more than ~~\$51~~ \$53 per study. Fees collected under this  
354.15 subdivision are appropriated to the commissioner for purposes of conducting background  
354.16 studies.

354.17 Sec. 31. Minnesota Statutes 2022, section 245C.10, subdivision 21, is amended to read:

354.18 Subd. 21. **Board of School Administrators.** The commissioner shall recover the cost  
354.19 of background studies initiated by the Board of School Administrators through a fee of no  
354.20 more than ~~\$51~~ \$53 per study. Fees collected under this subdivision are appropriated to the  
354.21 commissioner for purposes of conducting background studies.

354.22 Sec. 32. Minnesota Statutes 2022, section 245C.10, is amended by adding a subdivision  
354.23 to read:

354.24 Subd. 22. **Tribal organizations.** The commissioner shall recover the cost of background  
354.25 studies initiated by Tribal organizations under section 245C.34 for adoption and child foster  
354.26 care. The fee amount shall be established through interagency agreements between the  
354.27 commissioner and Tribal organizations or their designees. The fees collected under this  
354.28 subdivision shall be deposited in the special revenue fund and are appropriated to the  
354.29 commissioner for the purpose of conducting background studies and criminal background  
354.30 checks. This change shall go into effect July 1, 2024.

355.1 Sec. 33. Minnesota Statutes 2022, section 245C.17, subdivision 2, is amended to read:

355.2 Subd. 2. **Disqualification notice sent to subject.** (a) If the information in the study  
355.3 indicates the individual is disqualified from direct contact with, or from access to, persons  
355.4 served by the program, the commissioner shall disclose to the individual studied:

355.5 (1) the information causing disqualification;

355.6 (2) instructions on how to request a reconsideration of the disqualification;

355.7 (3) an explanation of any restrictions on the commissioner's discretion to set aside the  
355.8 disqualification under section 245C.24, when applicable to the individual;

355.9 ~~(4) a statement that, if the individual's disqualification is set aside under section 245C.22,~~  
355.10 ~~the applicant, license holder, or other entity that initiated the background study will be~~  
355.11 ~~provided with the reason for the individual's disqualification and an explanation that the~~  
355.12 ~~factors under section 245C.22, subdivision 4, which were the basis of the decision to set~~  
355.13 ~~aside the disqualification shall be made available to the license holder upon request without~~  
355.14 ~~the consent of the subject of the background study;~~

355.15 ~~(5) a statement indicating that if the individual's disqualification is set aside or the facility~~  
355.16 ~~is granted a variance under section 245C.30, the individual's identity and the reason for the~~  
355.17 ~~individual's disqualification will become public data under section 245C.22, subdivision 7,~~  
355.18 ~~when applicable to the individual;~~

355.19 ~~(6)~~ (4) a statement that when a subsequent background study is initiated on the individual  
355.20 following a set-aside of the individual's disqualification, and the commissioner makes a  
355.21 determination under section 245C.22, subdivision 5, paragraph (b), that the previous set-aside  
355.22 applies to the subsequent background study, the applicant, license holder, or other entity  
355.23 that initiated the background study will be informed in the notice under section 245C.22,  
355.24 subdivision 5, paragraph (c):

355.25 (i) of the reason for the individual's disqualification; and

355.26 ~~(ii) that the individual's disqualification is set aside for that program or agency; and~~

355.27 ~~(iii) that information about the factors under section 245C.22, subdivision 4, that were~~  
355.28 ~~the basis of the decision to set aside the disqualification are available to the license holder~~  
355.29 ~~upon request without the consent of the background study subject; and~~

355.30 ~~(7)~~ (5) the commissioner's determination of the individual's immediate risk of harm  
355.31 under section 245C.16.

356.1 (b) If the commissioner determines under section 245C.16 that an individual poses an  
356.2 imminent risk of harm to persons served by the program where the individual will have  
356.3 direct contact with, or access to, people receiving services, the commissioner's notice must  
356.4 include an explanation of the basis of this determination.

356.5 (c) If the commissioner determines under section 245C.16 that an individual studied  
356.6 does not pose a risk of harm that requires immediate removal, the individual shall be informed  
356.7 of the conditions under which the agency that initiated the background study may allow the  
356.8 individual to have direct contact with, or access to, people receiving services, as provided  
356.9 under subdivision 3.

356.10 Sec. 34. Minnesota Statutes 2022, section 245C.17, subdivision 3, is amended to read:

356.11 Subd. 3. **Disqualification notification.** (a) The commissioner shall notify an applicant,  
356.12 license holder, or other entity as provided in this chapter who is not the subject of the study:

356.13 (1) that the commissioner has found information that disqualifies the individual studied  
356.14 from being in a position allowing direct contact with, or access to, people served by the  
356.15 program; and

356.16 (2) the commissioner's determination of the individual's risk of harm under section  
356.17 245C.16.

356.18 (b) If the commissioner determines under section 245C.16 that an individual studied  
356.19 poses an imminent risk of harm to persons served by the program where the individual  
356.20 studied will have direct contact with, or access to, people served by the program, the  
356.21 commissioner shall order the license holder to immediately remove the individual studied  
356.22 from any position allowing direct contact with, or access to, people served by the program.

356.23 (c) If the commissioner determines under section 245C.16 that an individual studied  
356.24 poses a risk of harm that requires continuous, direct supervision, the commissioner shall  
356.25 order the applicant, license holder, or other entities as provided in this chapter to:

356.26 (1) immediately remove the individual studied from any position allowing direct contact  
356.27 with, or access to, people receiving services; or

356.28 (2) before allowing the disqualified individual to be in a position allowing direct contact  
356.29 with, or access to, people receiving services, the applicant, license holder, or other entity,  
356.30 as provided in this chapter, must:

356.31 ~~(i) obtain from the disqualified individual a copy of the individual's notice of~~  
356.32 ~~disqualification from the commissioner that explains the reason for disqualification;~~

357.1 ~~(ii)~~ (i) ensure that the individual studied is under continuous, direct supervision when  
357.2 in a position allowing direct contact with, or access to, people receiving services during the  
357.3 period in which the individual may request a reconsideration of the disqualification under  
357.4 section 245C.21; and

357.5 ~~(iii)~~ (ii) ensure that the disqualified individual requests reconsideration within 30 days  
357.6 of receipt of the notice of disqualification.

357.7 (d) If the commissioner determines under section 245C.16 that an individual studied  
357.8 does not pose a risk of harm that requires continuous, direct supervision, the commissioner  
357.9 shall order the applicant, license holder, or other entities as provided in this chapter to:

357.10 (1) immediately remove the individual studied from any position allowing direct contact  
357.11 with, or access to, people receiving services; or

357.12 (2) before allowing the disqualified individual to be in any position allowing direct  
357.13 contact with, or access to, people receiving services, the applicant, license holder, or other  
357.14 entity as provided in this chapter must:

357.15 ~~(i) obtain from the disqualified individual a copy of the individual's notice of~~  
357.16 ~~disqualification from the commissioner that explains the reason for disqualification; and~~

357.17 ~~(ii)~~ ensure that the disqualified individual requests reconsideration within 15 days of  
357.18 receipt of the notice of disqualification.

357.19 (e) The commissioner shall not notify the applicant, license holder, or other entity as  
357.20 provided in this chapter of the information contained in the subject's background study  
357.21 unless:

357.22 (1) the basis for the disqualification is failure to cooperate with the background study  
357.23 ~~or substantiated maltreatment under section 626.557 or chapter 260E;~~

357.24 (2) the Data Practices Act under chapter 13 provides for release of the information; or

357.25 (3) the individual studied authorizes the release of the information.

357.26 Sec. 35. Minnesota Statutes 2022, section 245C.22, subdivision 7, is amended to read:

357.27 Subd. 7. **Classification of certain data.** (a) Notwithstanding section 13.46, except as  
357.28 provided in paragraph ~~(f)~~ (e), upon setting aside a disqualification under this section, the  
357.29 identity of the disqualified individual who received the set-aside and the individual's  
357.30 disqualifying characteristics are public private data ~~if the set-aside was:~~

358.1 ~~(1) for any disqualifying characteristic under section 245C.15, except a felony-level~~  
358.2 ~~conviction for a drug-related offense within the past five years, when the set-aside relates~~  
358.3 ~~to a child care center or a family child care provider licensed under chapter 245A, certified~~  
358.4 ~~license-exempt child care center, or legal nonlicensed family child care; or~~

358.5 ~~(2) for a disqualifying characteristic under section 245C.15, subdivision 2.~~

358.6 (b) Notwithstanding section 13.46, upon granting a variance to a license holder under  
358.7 section 245C.30, the identity of the disqualified individual who is the subject of the variance,  
358.8 the individual's disqualifying characteristics under section 245C.15, and the terms of the  
358.9 variance are ~~public data, except as provided in paragraph (c), clause (6), when the variance:~~  
358.10 private.

358.11 ~~(1) is issued to a child care center or a family child care provider licensed under chapter~~  
358.12 ~~245A; or~~

358.13 ~~(2) relates to an individual with a disqualifying characteristic under section 245C.15,~~  
358.14 ~~subdivision 2.~~

358.15 (c) The identity of a disqualified individual and the reason for disqualification remain  
358.16 private data when:

358.17 (1) a disqualification is not set aside and no variance is granted, except as provided under  
358.18 section 13.46, subdivision 4;

358.19 (2) the data are not public under paragraph (a) or (b);

358.20 (3) the disqualification is rescinded because the information relied upon to disqualify  
358.21 the individual is incorrect;

358.22 (4) the disqualification relates to a license to provide relative child foster care. As used  
358.23 in this clause, "relative" has the meaning given it under section 260C.007, subdivision 26b  
358.24 or 27;

358.25 (5) the disqualified individual is a household member of a licensed foster care provider  
358.26 and:

358.27 (i) the disqualified individual previously received foster care services from this licensed  
358.28 foster care provider;

358.29 (ii) the disqualified individual was subsequently adopted by this licensed foster care  
358.30 provider; and

358.31 (iii) the disqualifying act occurred before the adoption; or

359.1 (6) a variance is granted to a child care center or family child care license holder for an  
359.2 individual's disqualification that is based on a felony-level conviction for a drug-related  
359.3 offense that occurred within the past five years.

359.4 ~~(d) Licensed family child care providers and child care centers must provide notices as~~  
359.5 ~~required under section 245C.301.~~

359.6 ~~(e)~~ (d) Notwithstanding paragraphs (a) and (b), the identity of household members who  
359.7 are the subject of a disqualification related set-aside or variance is not public data if:

359.8 (1) the household member resides in the residence where the family child care is provided;

359.9 (2) the subject of the set-aside or variance is under the age of 18 years; and

359.10 (3) the set-aside or variance only relates to a disqualification under section 245C.15,  
359.11 subdivision 4, for a misdemeanor-level theft crime as defined in section 609.52.

359.12 ~~(f)~~ (e) When the commissioner has reason to know that a disqualified individual has  
359.13 received an order for expungement for the disqualifying record that does not limit the  
359.14 commissioner's access to the record, and the record was opened or exchanged with the  
359.15 commissioner for purposes of a background study under this chapter, the data that would  
359.16 otherwise become public under paragraph (a) or (b) remain private data.

359.17 Sec. 36. Minnesota Statutes 2022, section 245C.23, subdivision 1, is amended to read:

359.18 Subdivision 1. **Disqualification that is rescinded or set aside.** (a) If the commissioner  
359.19 rescinds or sets aside a disqualification, the commissioner shall notify the applicant, license  
359.20 holder, or other entity in writing or by electronic transmission of the decision.

359.21 (b) In the notice from the commissioner that a disqualification has been rescinded, the  
359.22 commissioner must inform the applicant, license holder, or other entity that the information  
359.23 relied upon to disqualify the individual was incorrect.

359.24 ~~(e) Except as provided in paragraphs (d) and (e), in the notice from the commissioner~~  
359.25 ~~that a disqualification has been set aside, the commissioner must inform the applicant,~~  
359.26 ~~license holder, or other entity of the reason for the individual's disqualification and that~~  
359.27 ~~information about which factors under section 245C.22, subdivision 4, were the basis of~~  
359.28 ~~the decision to set aside the disqualification are available to the license holder upon request~~  
359.29 ~~without the consent of the background study subject.~~

359.30 ~~(d) When the commissioner has reason to know that a disqualified individual has received~~  
359.31 ~~an order for expungement for the disqualifying record that does not limit the commissioner's~~  
359.32 ~~access to the record, and the record was opened or exchanged with the commissioner for~~

360.1 ~~purposes of a background study under this chapter, the information provided under paragraph~~  
360.2 ~~(e) must only inform the applicant, license holder, or other entity that the disqualifying~~  
360.3 ~~criminal record is sealed under a court order.~~

360.4 ~~(e) The notification requirements in paragraph (e) do not apply when the set aside is~~  
360.5 ~~granted to an individual related to a background study for a licensed child care center,~~  
360.6 ~~certified license-exempt child care center, or family child care license holder, or for a legal~~  
360.7 ~~nonlicensed child care provider authorized under chapter 119B, and the individual is~~  
360.8 ~~disqualified for a felony-level conviction for a drug-related offense that occurred within the~~  
360.9 ~~past five years. The notice that the individual's disqualification is set aside must inform the~~  
360.10 ~~applicant, license holder, or legal nonlicensed child care provider that the disqualifying~~  
360.11 ~~criminal record is not public.~~

360.12 Sec. 37. Minnesota Statutes 2022, section 245C.32, subdivision 2, is amended to read:

360.13 Subd. 2. Use. (a) The commissioner may also use these systems and records to obtain  
360.14 and provide criminal history data from the Bureau of Criminal Apprehension, criminal  
360.15 history data held by the commissioner, and data about substantiated maltreatment under  
360.16 section 626.557 or chapter 260E, for other purposes, provided that:

360.17 (1) the background study is specifically authorized in statute; or

360.18 (2) the request is made with the informed consent of the subject of the study as provided  
360.19 in section 13.05, subdivision 4.

360.20 (b) An individual making a request under paragraph (a), clause (2), must agree in writing  
360.21 not to disclose the data to any other individual without the consent of the subject of the data.

360.22 (c) The commissioner may use these systems to share background study documentation  
360.23 electronically with entities and individuals who are the subject of a background study.

360.24 ~~(e)~~ (d) The commissioner may recover the cost of obtaining and providing background  
360.25 study data by charging the individual or entity requesting the study a fee ~~of no more than~~  
360.26 ~~\$42 per study~~ as described in section 245C.10. The fees collected under this paragraph are  
360.27 appropriated to the commissioner for the purpose of conducting background studies.

361.1 Sec. 38. Minnesota Statutes 2022, section 524.5-118, is amended to read:

361.2 **524.5-118 BACKGROUND STUDY MALTREATMENT AND STATE LICENSING**  
361.3 **AGENCY CHECKS; CRIMINAL HISTORY CHECK.**

361.4 Subdivision 1. **When required; exception.** (a) The court shall require ~~a background~~  
361.5 ~~study~~ maltreatment and state licensing agency checks and a criminal history check under  
361.6 this section:

361.7 (1) before the appointment of a guardian or conservator, unless ~~a background study has~~  
361.8 maltreatment and state licensing agency checks and a criminal history check have been  
361.9 done on the person under this section within the previous five years; and

361.10 (2) once every five years after the appointment, if the person continues to serve as a  
361.11 guardian or conservator.

361.12 (b) ~~The background study~~ maltreatment and state licensing agency checks and criminal  
361.13 history check under this section must include:

361.14 (1) criminal history data from the Bureau of Criminal Apprehension, ~~other criminal~~  
361.15 ~~history data held by the commissioner of human services, and data regarding whether the~~  
361.16 ~~person has been a perpetrator of substantiated maltreatment of a vulnerable adult or minor;~~

361.17 (2) criminal history data from a national criminal history record check ~~as defined in~~  
361.18 ~~section 245C.02, subdivision 13e; and~~

361.19 (3) state licensing agency data if a search of the database or databases of the agencies  
361.20 listed in subdivision 2a shows that the proposed guardian or conservator has ever held a  
361.21 professional license directly related to the responsibilities of a professional fiduciary from  
361.22 an agency listed in subdivision 2a that was conditioned, suspended, revoked, or canceled;  
361.23 and

361.24 (4) data regarding whether the person has been a perpetrator of substantiated maltreatment  
361.25 of a vulnerable adult or minor.

361.26 (c) If the guardian or conservator is not an individual, the ~~background study~~ maltreatment  
361.27 and state licensing agency checks and criminal history check must be done on all individuals  
361.28 currently employed by the proposed guardian or conservator who will be responsible for  
361.29 exercising powers and duties under the guardianship or conservatorship.

361.30 (d) Notwithstanding paragraph (a), if the court determines that it would be in the best  
361.31 interests of the person subject to guardianship or conservatorship to appoint a guardian or  
361.32 conservator before the ~~background study~~ maltreatment and state licensing agency checks

362.1 and criminal history check can be completed, the court may make the appointment pending  
 362.2 the results of the study checks, however, the ~~background study~~ maltreatment and state  
 362.3 licensing agency checks and criminal history check must then be completed as soon as  
 362.4 reasonably possible after appointment, ~~no later than 30 days after appointment.~~

362.5 (e) The ~~fee~~ fees for ~~background studies~~ the maltreatment and state licensing agency  
 362.6 checks and the criminal history check conducted under this section ~~is~~ are specified in ~~section~~  
 362.7 sections 245C.10, subdivision 14 15, and 299C.10, subdivisions 4 and 5. The ~~fee~~ fees for  
 362.8 conducting a ~~background study~~ these checks for appointment of a professional guardian or  
 362.9 conservator must be paid by the guardian or conservator. In other cases, the fee must be  
 362.10 paid as follows:

362.11 (1) if the matter is proceeding in forma pauperis, the fee is an expense for purposes of  
 362.12 section 524.5-502, paragraph (a);

362.13 (2) if there is an estate of the person subject to guardianship or conservatorship, the fee  
 362.14 must be paid from the estate; or

362.15 (3) in the case of a guardianship or conservatorship of the person that is not proceeding  
 362.16 in forma pauperis, the court may order that the fee be paid by the guardian or conservator  
 362.17 or by the court.

362.18 (f) The requirements of this subdivision do not apply if the guardian or conservator is:

362.19 (1) a state agency or county;

362.20 (2) a parent or guardian of a person proposed to be subject to guardianship or  
 362.21 conservatorship who has a developmental disability, if the parent or guardian has raised the  
 362.22 person proposed to be subject to guardianship or conservatorship in the family home until  
 362.23 the time the petition is filed, unless counsel appointed for the person proposed to be subject  
 362.24 to guardianship or conservatorship under section 524.5-205, paragraph (e); 524.5-304,  
 362.25 paragraph (b); 524.5-405, paragraph (a); or 524.5-406, paragraph (b), recommends a  
 362.26 background study; or

362.27 (3) a bank with trust powers, bank and trust company, or trust company, organized under  
 362.28 the laws of any state or of the United States and which is regulated by the commissioner of  
 362.29 commerce or a federal regulator.

362.30 Subd. 2. **Procedure; maltreatment and state licensing agency checks and criminal**  
 362.31 **history and maltreatment records background check.** (a) The ~~court~~ guardian or  
 362.32 conservator shall request the ~~commissioner of human services~~ Bureau of Criminal  
 362.33 Apprehension to complete a ~~background study under section 245C.32~~ criminal history

363.1 check. The request must be accompanied by the applicable fee and acknowledgment that  
363.2 the study subject guardian or conservator received a privacy notice ~~required under subdivision~~  
363.3 ~~3~~. The ~~commissioner of human services~~ Bureau of Criminal Apprehension shall conduct a  
363.4 national criminal history record check. The study subject guardian or conservator shall  
363.5 submit a set of classifiable fingerprints. The fingerprints must be recorded on a fingerprint  
363.6 card provided by the ~~commissioner of human services~~ Bureau of Criminal Apprehension.

363.7 (b) The ~~commissioner of human services~~ Bureau of Criminal Apprehension shall provide  
363.8 the court with criminal history data as defined in section 13.87 from the Bureau of Criminal  
363.9 Apprehension in the Department of Public Safety, ~~other criminal history data held by the~~  
363.10 ~~commissioner of human services, data regarding substantiated maltreatment of vulnerable~~  
363.11 ~~adults under section 626.557, and substantiated maltreatment of minors under chapter 260E,~~  
363.12 and criminal history information from other states or jurisdictions as indicated from a national  
363.13 criminal history record check within 20 working days of receipt of a request. In accordance  
363.14 with section 245C.033, the commissioner of human services shall provide the court with  
363.15 data regarding substantiated maltreatment of vulnerable adults under section 626.557, and  
363.16 substantiated maltreatment of minors under chapter 260E within 25 working days of receipt  
363.17 of a request. If the subject of the study guardian or conservator has been the perpetrator of  
363.18 substantiated maltreatment of a vulnerable adult or minor, the response must include a copy  
363.19 of the any available public portion of the investigation memorandum under section 626.557,  
363.20 subdivision 12b, or the any available public portion of the investigation memorandum under  
363.21 section 260E.30. The commissioner shall provide the court with information from a review  
363.22 of information according to subdivision 2a if the study subject provided information  
363.23 indicating current or prior affiliation with a state licensing agency.

363.24 (c) Notwithstanding section 260E.30 or 626.557, subdivision 12b, if the commissioner  
363.25 of human services or a county lead agency or lead investigative agency has information that  
363.26 a person ~~on whom a background study was previously done~~ under this section has been  
363.27 determined to be a perpetrator of maltreatment of a vulnerable adult or minor, the  
363.28 commissioner or the county may provide this information to the court that ~~requested the~~  
363.29 background study is determining eligibility for the guardian or conservator. The commissioner  
363.30 may also provide the court with additional criminal history or substantiated maltreatment  
363.31 information that becomes available after the background study is done.

363.32 Subd. 2a. **Procedure; state licensing agency data.** (a) In response to a request submitted  
363.33 under section 245C.033, the court shall request the commissioner of human services to shall  
363.34 provide the court within 25 working days of receipt of the request with licensing agency  
363.35 data for licenses directly related to the responsibilities of a professional fiduciary if the study

364.1 ~~subject indicates~~ guardian or conservator has a current or prior affiliation from the following  
364.2 agencies in Minnesota:

364.3 (1) Lawyers Responsibility Board;

364.4 (2) State Board of Accountancy;

364.5 (3) Board of Social Work;

364.6 (4) Board of Psychology;

364.7 (5) Board of Nursing;

364.8 (6) Board of Medical Practice;

364.9 (7) Department of Education;

364.10 (8) Department of Commerce;

364.11 (9) Board of Chiropractic Examiners;

364.12 (10) Board of Dentistry;

364.13 (11) Board of Marriage and Family Therapy;

364.14 (12) Department of Human Services;

364.15 (13) Peace Officer Standards and Training (POST) Board; and

364.16 (14) Professional Educator Licensing and Standards Board.

364.17 ~~(b) The commissioner shall enter into agreements with these agencies to provide the~~  
364.18 ~~commissioner with electronic access to the relevant licensing data, and to provide the~~  
364.19 ~~commissioner with a quarterly list of new sanctions issued by the agency.~~

364.20 ~~(e) (b) The commissioner shall provide information to the court the electronically~~  
364.21 ~~available data maintained in the agency's database, including whether the proposed guardian~~  
364.22 ~~or conservator is or has been licensed by the agency, and if the licensing agency database~~  
364.23 ~~indicates a disciplinary action or a sanction against the individual's license, including a~~  
364.24 ~~condition, suspension, revocation, or cancellation in accordance with section 245C.033.~~

364.25 ~~(d) If the proposed guardian or conservator has resided in a state other than Minnesota~~  
364.26 ~~in the previous ten years, licensing agency data under this section shall also include the~~  
364.27 ~~licensing agency data from any other state where the proposed guardian or conservator~~  
364.28 ~~reported to have resided during the previous ten years if the study subject indicates current~~  
364.29 ~~or prior affiliation. If the proposed guardian or conservator has or has had a professional~~  
364.30 ~~license in another state that is directly related to the responsibilities of a professional fiduciary~~

365.1 ~~from one of the agencies listed under paragraph (a), state licensing agency data shall also~~  
365.2 ~~include data from the relevant licensing agency of that state.~~

365.3 ~~(e) The commissioner is not required to repeat a search for Minnesota or out-of-state~~  
365.4 ~~licensing data on an individual if the commissioner has provided this information to the~~  
365.5 ~~court within the prior five years.~~

365.6 ~~(f) The commissioner shall review the information in paragraph (e) at least once every~~  
365.7 ~~four months to determine if an individual who has been studied within the previous five~~  
365.8 ~~years:~~

365.9 ~~(1) has new disciplinary action or sanction against the individual's license; or~~

365.10 ~~(2) did not disclose a prior or current affiliation with a Minnesota licensing agency.~~

365.11 ~~(g) If the commissioner's review in paragraph (f) identifies new information, the~~  
365.12 ~~commissioner shall provide any new information to the court.~~

365.13 ~~Subd. 3. **Forms and systems.** The court~~ In accordance with section 245C.033, subdivision  
365.14 3, the commissioner must provide the study subject guardian or conservator with a privacy  
365.15 notice for the maltreatment and state licensing agency checks that complies with section  
365.16 245C.05, subdivision 2e 13.04, subdivision 2. The commissioner of human services shall  
365.17 use the NETStudy 2.0 system to conduct a background study under this section. The Bureau  
365.18 of Criminal Apprehension must provide the guardian or conservator with a privacy notice  
365.19 for the criminal history check.

365.20 ~~Subd. 4. **Rights.** The court shall notify the subject of a background study guardian or~~  
365.21 ~~conservator that the subject has they have the following rights:~~

365.22 ~~(1) the right to be informed that the court will request a background study on the subject~~  
365.23 maltreatment and state licensing agency checks and a criminal history check on the guardian  
365.24 or conservator for the purpose of determining whether the person's appointment or continued  
365.25 appointment is in the best interests of the person subject to guardianship or conservatorship;

365.26 ~~(2) the right to be informed of the results of the study and to obtain from the court a~~  
365.27 ~~copy of the results; and~~

365.28 ~~(3) the right to challenge the accuracy and completeness of information contained in the~~  
365.29 ~~results under section 13.04, subdivision 4, except to the extent precluded by section 256.045,~~  
365.30 ~~subdivision 3.~~

366.1 Sec. 39. **REPEALER.**

366.2 Minnesota Statutes 2022, sections 245C.02, subdivision 14b; 245C.031, subdivisions  
366.3 5, 6, and 7; 245C.032; and 245C.30, subdivision 1a, are repealed.

366.4 **ARTICLE 7**

366.5 **BEHAVIORAL HEALTH**

366.6 Section 1. Minnesota Statutes 2022, section 245I.04, subdivision 14, is amended to read:

366.7 Subd. 14. **Mental health rehabilitation worker qualifications.** (a) A mental health  
366.8 rehabilitation worker must:

366.9 (1) have a high school diploma or equivalent; ~~and~~

366.10 (2) have the training required under section 245I.05, subdivision 3, paragraph (c); and

366.11 ~~(2)~~ (3) meet one of the following qualification requirements:

366.12 (i) be fluent in the non-English language or competent in the culture of the ethnic group  
366.13 to which at least 20 percent of the mental health rehabilitation worker's clients belong;

366.14 (ii) have an associate of arts degree;

366.15 (iii) have two years of full-time postsecondary education or a total of 15 semester hours  
366.16 or 23 quarter hours in behavioral sciences or related fields;

366.17 (iv) be a registered nurse;

366.18 (v) have, within the previous ten years, three years of personal life experience with  
366.19 mental illness;

366.20 (vi) have, within the previous ten years, three years of life experience as a primary  
366.21 caregiver to an adult with a mental illness, traumatic brain injury, substance use disorder,  
366.22 or developmental disability; or

366.23 (vii) have, within the previous ten years, 2,000 hours of work experience providing  
366.24 health and human services to individuals.

366.25 (b) A mental health rehabilitation worker who is exclusively scheduled as an overnight  
366.26 staff person ~~and works alone~~ is exempt from the additional qualification requirements in  
366.27 paragraph (a), clause ~~(2)~~ (3).

367.1 Sec. 2. Minnesota Statutes 2022, section 245I.04, subdivision 16, is amended to read:

367.2 Subd. 16. **Mental health behavioral aide qualifications.** (a) A level 1 mental health  
367.3 behavioral aide must have the training required under section 245I.05, subdivision 3,  
367.4 paragraph (c), and: (1) a high school diploma or equivalent; or (2) two years of experience  
367.5 as a primary caregiver to a child with mental illness within the previous ten years.

367.6 (b) A level 2 mental health behavioral aide must: ~~(1) have the training required under~~  
367.7 ~~section 245I.05, subdivision 3, paragraph (c), and an associate or bachelor's degree; or (2)~~  
367.8 ~~be certified by a program under section 256B.0943, subdivision 8a.~~

367.9 Sec. 3. Minnesota Statutes 2022, section 245I.08, subdivision 2, is amended to read:

367.10 Subd. 2. **Documentation standards.** A license holder must ensure that all documentation  
367.11 required by this chapter:

367.12 (1) is legible;

367.13 (2) identifies the applicable client name on each page of the client file and staff person  
367.14 name on each page of the personnel file; and

367.15 (3) is signed and dated by the staff persons who provided services to the client or  
367.16 completed the documentation, including the staff persons' credentials.

367.17 Sec. 4. Minnesota Statutes 2022, section 245I.08, subdivision 4, is amended to read:

367.18 Subd. 4. **Progress notes.** A license holder must use a progress note to document each  
367.19 occurrence of a mental health service that a staff person provides to a client. A progress  
367.20 note must include the following:

367.21 (1) the type of service;

367.22 (2) the date of service;

367.23 (3) the start and stop time of the service unless the license holder is licensed as a  
367.24 residential program;

367.25 (4) the location of the service;

367.26 (5) the scope of the service, including: (i) the targeted goal and objective; (ii) the  
367.27 intervention that the staff person provided to the client and the methods that the staff person  
367.28 used; (iii) the client's response to the intervention; and (iv) the staff person's plan to take  
367.29 future actions, including changes in treatment that the staff person will implement if the  
367.30 intervention was ineffective; ~~and (v) the service modality;~~

368.1 (6) the signature and credentials of the staff person who provided the service to the  
368.2 client;

368.3 (7) the mental health provider travel documentation required by section 256B.0625, if  
368.4 applicable; and

368.5 (8) significant observations by the staff person, if applicable, including: (i) the client's  
368.6 current risk factors; (ii) emergency interventions by staff persons; (iii) consultations with  
368.7 or referrals to other professionals, family, or significant others; and (iv) changes in the  
368.8 client's mental or physical symptoms.

368.9 Sec. 5. Minnesota Statutes 2022, section 245I.10, subdivision 2, is amended to read:

368.10 Subd. 2. **Generally.** (a) A license holder must use a client's diagnostic assessment or  
368.11 crisis assessment to determine a client's eligibility for mental health services, except as  
368.12 provided in this section.

368.13 (b) Prior to completing a client's initial diagnostic assessment, a license holder may  
368.14 provide a client with the following services:

368.15 (1) an explanation of findings;

368.16 (2) neuropsychological testing, neuropsychological assessment, and psychological  
368.17 testing;

368.18 (3) any combination of psychotherapy sessions, family psychotherapy sessions, and  
368.19 family psychoeducation sessions not to exceed three sessions;

368.20 (4) crisis assessment services according to section 256B.0624; and

368.21 (5) ten days of intensive residential treatment services according to the assessment and  
368.22 treatment planning standards in section 245I.23, subdivision 7.

368.23 (c) Based on the client's needs that a crisis assessment identifies under section 256B.0624,  
368.24 a license holder may provide a client with the following services:

368.25 (1) crisis intervention and stabilization services under section 245I.23 or 256B.0624;  
368.26 and

368.27 (2) any combination of psychotherapy sessions, group psychotherapy sessions, family  
368.28 psychotherapy sessions, and family psychoeducation sessions not to exceed ten sessions  
368.29 within a 12-month period without prior authorization.

368.30 (d) Based on the client's needs in the client's brief diagnostic assessment, a license holder  
368.31 may provide a client with any combination of psychotherapy sessions, group psychotherapy

369.1 sessions, family psychotherapy sessions, and family psychoeducation sessions not to exceed  
369.2 ten sessions within a 12-month period without prior authorization for any new client or for  
369.3 an existing client who the license holder projects will need fewer than ten sessions during  
369.4 the next 12 months.

369.5 (e) Based on the client's needs that a hospital's medical history and presentation  
369.6 examination identifies, a license holder may provide a client with:

369.7 (1) any combination of psychotherapy sessions, group psychotherapy sessions, family  
369.8 psychotherapy sessions, and family psychoeducation sessions not to exceed ten sessions  
369.9 within a 12-month period without prior authorization for any new client or for an existing  
369.10 client who the license holder projects will need fewer than ten sessions during the next 12  
369.11 months; and

369.12 (2) up to five days of day treatment services or partial hospitalization.

369.13 (f) A license holder must complete a new standard diagnostic assessment of a client or  
369.14 an update to an assessment as permitted under paragraph (g):

369.15 (1) when the client requires services of a greater number or intensity than the services  
369.16 that paragraphs (b) to (e) describe;

369.17 (2) at least annually following the client's initial diagnostic assessment if the client needs  
369.18 additional mental health services and the client does not meet the criteria for a brief  
369.19 assessment;

369.20 (3) when the client's mental health condition has changed markedly since the client's  
369.21 most recent diagnostic assessment; or

369.22 (4) when the client's current mental health condition does not meet the criteria of the  
369.23 client's current diagnosis.

369.24 (g) For ~~an existing~~ a client who is already engaged in services and has a prior assessment,  
369.25 ~~the license holder must ensure that a new standard diagnostic assessment includes~~ complete  
369.26 a written update containing all significant new or changed information about the client,  
369.27 removal of outdated or inaccurate information, and an update regarding what information  
369.28 has not significantly changed, including a discussion with the client about changes in the  
369.29 client's life situation, functioning, presenting problems, and progress with achieving treatment  
369.30 goals since the client's last diagnostic assessment was completed.

370.1 Sec. 6. Minnesota Statutes 2022, section 245I.10, subdivision 3, is amended to read:

370.2 Subd. 3. **Continuity of services.** (a) For any client with a diagnostic assessment  
370.3 completed under Minnesota Rules, parts 9505.0370 to 9505.0372, before July 1, 2022, or  
370.4 upon federal approval, whichever is later, the diagnostic assessment is valid for authorizing  
370.5 the client's treatment and billing for one calendar year after the date that the assessment was  
370.6 completed.

370.7 (b) For any client with an individual treatment plan completed under section 256B.0622,  
370.8 256B.0623, 256B.0943, 256B.0946, or 256B.0947 or Minnesota Rules, parts 9505.0370 to  
370.9 9505.0372, the client's treatment plan is valid for authorizing treatment and billing until the  
370.10 treatment plan's expiration date.

370.11 (c) This subdivision expires ~~July 1~~ October 17, 2023.

370.12 Sec. 7. Minnesota Statutes 2022, section 245I.10, subdivision 6, is amended to read:

370.13 Subd. 6. **Standard diagnostic assessment; required elements.** (a) Only a mental health  
370.14 professional or a clinical trainee may complete a standard diagnostic assessment of a client.  
370.15 A standard diagnostic assessment of a client must include a face-to-face interview with a  
370.16 client and a written evaluation of the client. The assessor must complete a client's standard  
370.17 diagnostic assessment within the client's cultural context.

370.18 (b) When completing a standard diagnostic assessment of a client, the assessor must  
370.19 gather and document information about the client's current life situation, including the  
370.20 following information:

370.21 (1) the client's age;

370.22 (2) the client's current living situation, including the client's housing status and household  
370.23 members;

370.24 (3) the status of the client's basic needs;

370.25 (4) the client's education level and employment status;

370.26 (5) the client's current medications;

370.27 (6) any immediate risks to the client's health and safety;

370.28 (7) the client's perceptions of the client's condition;

370.29 (8) the client's description of the client's symptoms, including the reason for the client's  
370.30 referral;

370.31 (9) the client's history of mental health treatment; and

371.1 (10) cultural influences on the client.

371.2 (c) If the assessor cannot obtain the information that this paragraph requires without  
371.3 retraumatizing the client or harming the client's willingness to engage in treatment, the  
371.4 assessor must identify which topics will require further assessment during the course of the  
371.5 client's treatment. The assessor must gather and document information related to the following  
371.6 topics:

371.7 (1) the client's relationship with the client's family and other significant personal  
371.8 relationships, including the client's evaluation of the quality of each relationship;

371.9 (2) the client's strengths and resources, including the extent and quality of the client's  
371.10 social networks;

371.11 (3) important developmental incidents in the client's life;

371.12 (4) maltreatment, trauma, potential brain injuries, and abuse that the client has suffered;

371.13 (5) the client's history of or exposure to alcohol and drug usage and treatment; and

371.14 (6) the client's health history and the client's family health history, including the client's  
371.15 physical, chemical, and mental health history.

371.16 (d) When completing a standard diagnostic assessment of a client, an assessor must use  
371.17 a recognized diagnostic framework.

371.18 (1) When completing a standard diagnostic assessment of a client who is five years of  
371.19 age or younger, the assessor must use the current edition of the DC: 0-5 Diagnostic  
371.20 Classification of Mental Health and Development Disorders of Infancy and Early Childhood  
371.21 published by Zero to Three.

371.22 (2) When completing a standard diagnostic assessment of a client who is six years of  
371.23 age or older, the assessor must use the current edition of the Diagnostic and Statistical  
371.24 Manual of Mental Disorders published by the American Psychiatric Association.

371.25 (3) When completing a standard diagnostic assessment of a client who is five years of  
371.26 age or younger, an assessor must administer the Early Childhood Service Intensity Instrument  
371.27 (ECSII) to the client and include the results in the client's assessment.

371.28 (4) When completing a standard diagnostic assessment of a client who is six to 17 years  
371.29 of age, an assessor must administer the Child and Adolescent Service Intensity Instrument  
371.30 (CASII) to the client and include the results in the client's assessment.

371.31 (5) When completing a standard diagnostic assessment of a client who is 18 years of  
371.32 age or older, an assessor must use either (i) the CAGE-AID Questionnaire or (ii) the criteria

372.1 in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders  
372.2 published by the American Psychiatric Association to screen and assess the client for a  
372.3 substance use disorder.

372.4 (e) When completing a standard diagnostic assessment of a client, the assessor must  
372.5 include and document the following components of the assessment:

372.6 (1) the client's mental status examination;

372.7 (2) the client's baseline measurements; symptoms; behavior; skills; abilities; resources;  
372.8 vulnerabilities; safety needs, including client information that supports the assessor's findings  
372.9 after applying a recognized diagnostic framework from paragraph (d); and any differential  
372.10 diagnosis of the client;

372.11 (3) an explanation of: (i) how the assessor diagnosed the client using the information  
372.12 from the client's interview, assessment, psychological testing, and collateral information  
372.13 about the client; (ii) the client's needs; (iii) the client's risk factors; (iv) the client's strengths;  
372.14 and (v) the client's responsivity factors.

372.15 (f) When completing a standard diagnostic assessment of a client, the assessor must  
372.16 consult the client and the client's family about which services that the client and the family  
372.17 prefer to treat the client. The assessor must make referrals for the client as to services required  
372.18 by law.

372.19 (g) Information from other providers and prior assessments may be used to complete  
372.20 the diagnostic assessment if the source of the information is documented in the diagnostic  
372.21 assessment.

372.22 Sec. 8. Minnesota Statutes 2022, section 245I.10, subdivision 7, is amended to read:

372.23 Subd. 7. **Individual treatment plan.** A license holder must follow each client's written  
372.24 individual treatment plan when providing services to the client with the following exceptions:

372.25 (1) services that do not require that a license holder completes a standard diagnostic  
372.26 assessment of a client before providing services to the client;

372.27 (2) when developing a treatment or service plan; and

372.28 (3) when a client re-engages in services under subdivision 8, paragraph (b).

372.29 Sec. 9. Minnesota Statutes 2022, section 245I.10, subdivision 8, is amended to read:

372.30 Subd. 8. **Individual treatment plan; required elements.** (a) After completing a client's  
372.31 diagnostic assessment or reviewing a client's diagnostic assessment received from a different

373.1 provider, and before providing services to the client beyond those permitted under subdivision  
373.2 7, the license holder must complete the client's individual treatment plan. The license holder  
373.3 must:

373.4 (1) base the client's individual treatment plan on the client's diagnostic assessment and  
373.5 baseline measurements;

373.6 (2) for a child client, use a child-centered, family-driven, and culturally appropriate  
373.7 planning process that allows the child's parents and guardians to observe and participate in  
373.8 the child's individual and family treatment services, assessments, and treatment planning;

373.9 (3) for an adult client, use a person-centered, culturally appropriate planning process  
373.10 that allows the client's family and other natural supports to observe and participate in the  
373.11 client's treatment services, assessments, and treatment planning;

373.12 (4) identify the client's treatment goals, measureable treatment objectives, a schedule  
373.13 for accomplishing the client's treatment goals and objectives, a treatment strategy, and the  
373.14 individuals responsible for providing treatment services and supports to the client. The  
373.15 license holder must have a treatment strategy to engage the client in treatment if the client:

373.16 (i) has a history of not engaging in treatment; and

373.17 (ii) is ordered by a court to participate in treatment services or to take neuroleptic  
373.18 medications;

373.19 (5) identify the participants involved in the client's treatment planning. The client must  
373.20 be a participant in the client's treatment planning. If applicable, the license holder must  
373.21 document the reasons that the license holder did not involve the client's family or other  
373.22 natural supports in the client's treatment planning;

373.23 (6) review the client's individual treatment plan every 180 days and update the client's  
373.24 individual treatment plan with the client's treatment progress, new treatment objectives and  
373.25 goals or, if the client has not made treatment progress, changes in the license holder's  
373.26 approach to treatment; and

373.27 (7) ensure that the client approves of the client's individual treatment plan unless a court  
373.28 orders the client's treatment plan under chapter 253B.

373.29 (b) If the client disagrees with the client's treatment plan, the license holder must  
373.30 document in the client file the reasons why the client does not agree with the treatment plan.  
373.31 If the license holder cannot obtain the client's approval of the treatment plan, a mental health  
373.32 professional must make efforts to obtain approval from a person who is authorized to consent  
373.33 on the client's behalf within 30 days after the client's previous individual treatment plan

374.1 expired. A license holder may not deny a client service during this time period solely because  
374.2 the license holder could not obtain the client's approval of the client's individual treatment  
374.3 plan. A license holder may continue to bill for the client's otherwise eligible services when  
374.4 the client re-engages in services.

374.5 Sec. 10. Minnesota Statutes 2022, section 245I.11, subdivision 3, is amended to read:

374.6 Subd. 3. **Storing and accounting for medications.** (a) If a license holder stores client  
374.7 medications, the license holder must:

374.8 (1) store client medications in original containers in a locked location;

374.9 (2) store refrigerated client medications in special trays or containers that are separate  
374.10 from food;

374.11 (3) store client medications marked "for external use only" in a compartment that is  
374.12 separate from other client medications;

374.13 (4) store Schedule II ~~to IV~~ drugs listed in section 152.02, ~~subdivisions~~ subdivision 3 to  
374.14 5, in a compartment that is locked separately from other medications;

374.15 (5) ensure that only authorized staff persons have access to stored client medications;

374.16 (6) follow a documentation procedure ~~on each shift~~ to account for all ~~scheduled~~ Schedule  
374.17 II to V drugs listed in section 152.02, subdivisions 3 to 6; and

374.18 (7) record each incident when a staff person accepts a supply of client medications and  
374.19 destroy discontinued, outdated, or deteriorated client medications.

374.20 (b) If a license holder is licensed as a residential program, the license holder must allow  
374.21 clients who self-administer medications to keep a private medication supply. The license  
374.22 holder must ensure that the client stores all private medication in a locked container in the  
374.23 client's private living area, unless the private medication supply poses a health and safety  
374.24 risk to any clients. A client must not maintain a private medication supply of a prescription  
374.25 medication without a written medication order from a licensed prescriber and a prescription  
374.26 label that includes the client's name.

374.27 Sec. 11. Minnesota Statutes 2022, section 245I.11, subdivision 4, is amended to read:

374.28 Subd. 4. **Medication orders.** (a) If a license holder stores, prescribes, or administers  
374.29 medications or observes a client self-administer medications, the license holder must:

374.30 (1) ensure that a licensed prescriber writes all orders to accept, administer, or discontinue  
374.31 client medications;

375.1 (2) accept nonwritten orders to administer client medications in emergency circumstances  
375.2 only;

375.3 (3) establish a timeline and process for obtaining a written order with the licensed  
375.4 prescriber's signature when the license holder accepts a nonwritten order to administer client  
375.5 medications; and

375.6 ~~(4) obtain prescription medication renewals from a licensed prescriber for each client~~  
375.7 ~~every 90 days for psychotropic medications and annually for all other medications; and~~

375.8 ~~(5)~~ (4) maintain the client's right to privacy and dignity.

375.9 (b) If a license holder employs a licensed prescriber, the license holder must inform the  
375.10 client about potential medication effects and side effects and obtain and document the client's  
375.11 informed consent before the licensed prescriber prescribes a medication.

375.12 Sec. 12. Minnesota Statutes 2022, section 245I.20, subdivision 6, is amended to read:

375.13 Subd. 6. **Additional policy and procedure requirements.** (a) In addition to the policies  
375.14 and procedures required by section 245I.03, the certification holder must establish, enforce,  
375.15 and maintain the policies and procedures required by this subdivision.

375.16 (b) The certification holder must have a clinical evaluation procedure to identify and  
375.17 document each treatment team member's areas of competence.

375.18 (c) The certification holder must have policies and procedures for client intake and case  
375.19 assignment that:

375.20 (1) outline the client intake process;

375.21 (2) describe how the mental health clinic determines the appropriateness of accepting a  
375.22 client into treatment by reviewing the client's condition and need for treatment, the clinical  
375.23 services that the mental health clinic offers to clients, and other available resources; and

375.24 (3) contain a process for assigning a client's case to a mental health professional who is  
375.25 responsible for the client's case and other treatment team members.

375.26 (d) Notwithstanding the requirements under section 245I.10, subdivisions 5 to 10, for  
375.27 the required elements of a diagnostic assessment and a treatment plan, psychiatry billed as  
375.28 evaluation and management services must be documented in accordance with the most  
375.29 recent current procedural terminology as published by the American Medical Association.

376.1 Sec. 13. Minnesota Statutes 2022, section 254B.02, subdivision 5, is amended to read:

376.2 Subd. 5. ~~Administrative adjustment~~ Local agency allocation. The commissioner may  
376.3 make payments to local agencies from money allocated under this section to support  
376.4 ~~administrative activities under sections 254B.03 and 254B.04~~ individuals with substance  
376.5 use disorders. The ~~administrative~~ payment must not ~~exceed the lesser of: (1) five percent~~  
376.6 ~~of the first \$50,000, four percent of the next \$50,000, and three percent of the remaining~~  
376.7 ~~payments for services from the special revenue account according to subdivision 1; or (2)~~  
376.8 be less than 133 percent of the local agency ~~administrative~~ payment for the fiscal year ending  
376.9 June 30, 2009, adjusted in proportion to the statewide change in the appropriation for this  
376.10 chapter.

376.11 EFFECTIVE DATE. This section is effective the day following final enactment.

376.12 Sec. 14. Minnesota Statutes 2022, section 254B.05, subdivision 1, is amended to read:

376.13 Subdivision 1. **Licensure required.** (a) Programs licensed by the commissioner are  
376.14 eligible vendors. Hospitals may apply for and receive licenses to be eligible vendors,  
376.15 notwithstanding the provisions of section 245A.03. American Indian programs that provide  
376.16 substance use disorder treatment, extended care, transitional residence, or outpatient treatment  
376.17 services, and are licensed by tribal government are eligible vendors.

376.18 (b) A licensed professional in private practice as defined in section 245G.01, subdivision  
376.19 17, who meets the requirements of section 245G.11, subdivisions 1 and 4, is an eligible  
376.20 vendor of a comprehensive assessment and assessment summary provided according to  
376.21 section 245G.05, and treatment services provided according to sections 245G.06 and  
376.22 245G.07, subdivision 1, paragraphs (a), clauses (1) to (5), and (b); and subdivision 2, clauses  
376.23 (1) to (6).

376.24 (c) A county is an eligible vendor for a comprehensive assessment and assessment  
376.25 summary when provided by an individual who meets the staffing credentials of section  
376.26 245G.11, subdivisions 1 and 5, and completed according to the requirements of section  
376.27 245G.05. A county is an eligible vendor of care coordination services when provided by an  
376.28 individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 7, and  
376.29 provided according to the requirements of section 245G.07, subdivision 1, paragraph (a),  
376.30 clause (5).

376.31 (d) A recovery community organization that meets certification requirements identified  
376.32 by the commissioner is an eligible vendor of peer support services.

377.1 (e) Detoxification programs licensed under Minnesota Rules, parts 9530.6510 to  
377.2 9530.6590, are not eligible vendors. Programs that are not licensed as a residential or  
377.3 nonresidential substance use disorder treatment or withdrawal management program by the  
377.4 commissioner or by tribal government or do not meet the requirements of subdivisions 1a  
377.5 and 1b are not eligible vendors.

377.6 (f) Hospitals, federally qualified health centers, and rural health clinics are eligible  
377.7 vendors of a comprehensive assessment when the comprehensive assessment is completed  
377.8 according to section 245G.05 and by an individual who meets the criteria of an alcohol and  
377.9 drug counselor according to section 245G.11, subdivision 5. The alcohol and drug counselor  
377.10 must be individually enrolled with the commissioner and reported on the claim as the  
377.11 individual who provided the service.

377.12 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner  
377.13 of human services shall notify the revisor of statutes when federal approval is obtained.

377.14 Sec. 15. Minnesota Statutes 2022, section 254B.05, subdivision 1a, is amended to read:

377.15 Subd. 1a. **Room and board provider requirements.** (a) ~~Effective January 1, 2000,~~

377.16 Vendors of room and board are eligible for behavioral health fund payment if the vendor:

377.17 (1) has rules prohibiting residents bringing chemicals into the facility or using chemicals  
377.18 while residing in the facility and provide consequences for infractions of those rules;

377.19 (2) is determined to meet applicable health and safety requirements;

377.20 (3) is not a jail or prison;

377.21 (4) is not concurrently receiving funds under chapter 256I for the recipient;

377.22 (5) admits individuals who are 18 years of age or older;

377.23 (6) is registered as a board and lodging or lodging establishment according to section  
377.24 157.17;

377.25 (7) has awake staff on site 24 hours per day;

377.26 (8) has staff who are at least 18 years of age and meet the requirements of section  
377.27 245G.11, subdivision 1, paragraph (b);

377.28 (9) has emergency behavioral procedures that meet the requirements of section 245G.16;

377.29 (10) meets the requirements of section 245G.08, subdivision 5, if administering  
377.30 medications to clients;

378.1 (11) meets the abuse prevention requirements of section 245A.65, including a policy on  
378.2 fraternization and the mandatory reporting requirements of section 626.557;

378.3 (12) documents coordination with the treatment provider to ensure compliance with  
378.4 section 254B.03, subdivision 2;

378.5 (13) protects client funds and ensures freedom from exploitation by meeting the  
378.6 provisions of section 245A.04, subdivision 13;

378.7 (14) has a grievance procedure that meets the requirements of section 245G.15,  
378.8 subdivision 2; and

378.9 (15) has sleeping and bathroom facilities for men and women separated by a door that  
378.10 is locked, has an alarm, or is supervised by awake staff.

378.11 (b) Programs licensed according to Minnesota Rules, chapter 2960, are exempt from  
378.12 paragraph (a), clauses (5) to (15).

378.13 (c) Programs providing children's mental health crisis admissions and stabilization under  
378.14 section 245.4882, subdivision 6, are eligible vendors of room and board.

378.15 (d) Programs providing children's residential services under section 245.4882, except  
378.16 services for individuals who have a placement under chapter 260C or 260D, are eligible  
378.17 vendors of room and board.

378.18 ~~(d)~~ (e) Licensed programs providing intensive residential treatment services or residential  
378.19 crisis stabilization services pursuant to section 256B.0622 or 256B.0624 are eligible vendors  
378.20 of room and board and are exempt from paragraph (a), clauses (6) to (15).

378.21 **EFFECTIVE DATE.** This section is effective July 1, 2023.

378.22 Sec. 16. Minnesota Statutes 2022, section 256.478, subdivision 2, is amended to read:

378.23 Subd. 2. **Eligibility.** An individual is eligible for the transition to community initiative  
378.24 if the individual does not meet eligibility criteria for the medical assistance program under  
378.25 section 256B.056 or 256B.057, but who meets at least one of the following criteria:

378.26 (1) the person otherwise meets the criteria under section 256B.092, subdivision 13, or  
378.27 256B.49, subdivision 24;

378.28 (2) the person has met treatment objectives and no longer requires a hospital-level care  
378.29 or a secure treatment setting, but the person's discharge from the Anoka Metro Regional  
378.30 Treatment Center, the Minnesota ~~Security Hospital~~ Forensic Mental Health Program, the  
378.31 Child and Adolescent Behavioral Health Hospital program, a psychiatric residential treatment

379.1 facility under section 256B.0941, intensive residential treatment services under section  
379.2 256B.0622, children's residential services under section 245.4882, or a ~~community behavioral~~  
379.3 ~~health~~ hospital would be substantially delayed without additional resources available through  
379.4 the transitions to community initiative; or

379.5 ~~(3) the person is in a community hospital, but alternative community living options~~  
379.6 ~~would be appropriate for the person, and the person has received approval from the~~  
379.7 ~~commissioner; or~~

379.8 ~~(4)(i)~~ (3) the person (i) is receiving customized living services reimbursed under section  
379.9 256B.4914, 24-hour customized living services reimbursed under section 256B.4914, or  
379.10 community residential services reimbursed under section 256B.4914; ~~(ii) the person~~ expresses  
379.11 a desire to move; and ~~(iii) the person~~ has received approval from the commissioner.

379.12 **EFFECTIVE DATE.** This section is effective July 1, 2023.

379.13 Sec. 17. Minnesota Statutes 2022, section 256B.0622, subdivision 2a, is amended to read:

379.14 Subd. 2a. **Eligibility for assertive community treatment.** An eligible client for assertive  
379.15 community treatment is an individual who meets the following criteria as assessed by an  
379.16 ACT team:

379.17 (1) is age 18 or older. Individuals ages 16 and 17 may be eligible upon approval by the  
379.18 commissioner;

379.19 (2) has a primary diagnosis of schizophrenia, schizoaffective disorder, major depressive  
379.20 disorder with psychotic features, other psychotic disorders, or bipolar disorder. Individuals  
379.21 with other psychiatric illnesses may qualify for assertive community treatment if they have  
379.22 a serious mental illness and meet the criteria outlined in clauses (3) and (4), but no more  
379.23 than ten percent of an ACT team's clients may be eligible based on this criteria. Individuals  
379.24 with a primary diagnosis of a substance use disorder, intellectual developmental disabilities,  
379.25 borderline personality disorder, antisocial personality disorder, traumatic brain injury, or  
379.26 an autism spectrum disorder are not eligible for assertive community treatment;

379.27 (3) has significant functional impairment as demonstrated by at least one of the following  
379.28 conditions:

379.29 (i) significant difficulty consistently performing the range of routine tasks required for  
379.30 basic adult functioning in the community or persistent difficulty performing daily living  
379.31 tasks without significant support or assistance;

380.1 (ii) significant difficulty maintaining employment at a self-sustaining level or significant  
380.2 difficulty consistently carrying out the head-of-household responsibilities; or

380.3 (iii) significant difficulty maintaining a safe living situation;

380.4 (4) has a need for continuous high-intensity services as evidenced by at least two of the  
380.5 following:

380.6 (i) two or more psychiatric hospitalizations or residential crisis stabilization services in  
380.7 the previous 12 months;

380.8 (ii) frequent utilization of mental health crisis services in the previous six months;

380.9 (iii) 30 or more consecutive days of psychiatric hospitalization in the previous 24 months;

380.10 (iv) intractable, persistent, or prolonged severe psychiatric symptoms;

380.11 (v) coexisting mental health and substance use disorders lasting at least six months;

380.12 (vi) recent history of involvement with the criminal justice system or demonstrated risk  
380.13 of future involvement;

380.14 (vii) significant difficulty meeting basic survival needs;

380.15 (viii) residing in substandard housing, experiencing homelessness, or facing imminent  
380.16 risk of homelessness;

380.17 (ix) significant impairment with social and interpersonal functioning such that basic  
380.18 needs are in jeopardy;

380.19 (x) coexisting mental health and physical health disorders lasting at least six months;

380.20 (xi) residing in an inpatient or supervised community residence but clinically assessed  
380.21 to be able to live in a more independent living situation if intensive services are provided;

380.22 (xii) requiring a residential placement if more intensive services are not available; ~~or~~

380.23 (xiii) difficulty effectively using traditional office-based outpatient services; or

380.24 (xiv) receiving services under section 256B.0946 and continuing to meet the criteria but  
380.25 for turning age 21;

380.26 (5) there are no indications that other available community-based services would be  
380.27 equally or more effective as evidenced by consistent and extensive efforts to treat the  
380.28 individual; and

380.29 (6) in the written opinion of a licensed mental health professional, has the need for mental  
380.30 health services that cannot be met with other available community-based services, or is

381.1 likely to experience a mental health crisis or require a more restrictive setting if assertive  
381.2 community treatment is not provided.

381.3 Sec. 18. Minnesota Statutes 2022, section 256B.0622, subdivision 8, is amended to read:

381.4 Subd. 8. **Medical assistance payment for assertive community treatment and**  
381.5 **intensive residential treatment services.** (a) Payment for intensive residential treatment  
381.6 services and assertive community treatment in this section shall be based on one daily rate  
381.7 per provider inclusive of the following services received by an eligible client in a given  
381.8 calendar day: all rehabilitative services under this section, staff travel time to provide  
381.9 rehabilitative services under this section, and nonresidential crisis stabilization services  
381.10 under section 256B.0624.

381.11 (b) Except as indicated in paragraph (c), payment will not be made to more than one  
381.12 entity for each client for services provided under this section on a given day. If services  
381.13 under this section are provided by a team that includes staff from more than one entity, the  
381.14 team must determine how to distribute the payment among the members.

381.15 (c) The commissioner shall determine one rate for each provider that will bill medical  
381.16 assistance for residential services under this section and one rate for each assertive community  
381.17 treatment provider. If a single entity provides both services, one rate is established for the  
381.18 entity's residential services and another rate for the entity's nonresidential services under  
381.19 this section. A provider is not eligible for payment under this section without authorization  
381.20 from the commissioner. The commissioner shall develop rates using the following criteria:

381.21 (1) the provider's cost for services shall include direct services costs, other program  
381.22 costs, and other costs determined as follows:

381.23 (i) the direct services costs must be determined using actual costs of salaries, benefits,  
381.24 payroll taxes, and training of direct service staff and service-related transportation;

381.25 (ii) other program costs not included in item (i) must be determined as a specified  
381.26 percentage of the direct services costs as determined by item (i). The percentage used shall  
381.27 be determined by the commissioner based upon the average of percentages that represent  
381.28 the relationship of other program costs to direct services costs among the entities that provide  
381.29 similar services;

381.30 (iii) physical plant costs calculated based on the percentage of space within the program  
381.31 that is entirely devoted to treatment and programming. This does not include administrative  
381.32 or residential space;

382.1 (iv) assertive community treatment physical plant costs must be reimbursed as part of  
382.2 the costs described in item (ii); ~~and~~

382.3 (v) subject to federal approval, up to an additional five percent of the total rate may be  
382.4 added to the program rate as a quality incentive based upon the entity meeting performance  
382.5 criteria specified by the commissioner;

382.6 (vi) for assertive community treatment, intensive residential treatment services, and  
382.7 residential crisis services, providers may include in their prospective cost-based rate-setting  
382.8 methodology a line item reflecting estimated additional staffing compensation costs.

382.9 Estimated additional staffing compensation costs are subject to review by the commissioner;  
382.10 and

382.11 (vii) for intensive residential treatment services and residential crisis services, providers  
382.12 may include in their prospective cost-based rate-setting methodology a line item reflecting  
382.13 estimated new capital costs. Estimated new capital costs are subject to review by the  
382.14 commissioner;

382.15 (2) actual cost is defined as costs which are allowable, allocable, and reasonable, and  
382.16 consistent with federal reimbursement requirements under Code of Federal Regulations,  
382.17 title 48, chapter 1, part 31, relating to for-profit entities, and Office of Management and  
382.18 Budget Circular Number A-122, relating to nonprofit entities;

382.19 (3) the number of service units;

382.20 (4) the degree to which clients will receive services other than services under this section;  
382.21 and

382.22 (5) the costs of other services that will be separately reimbursed.

382.23 (d) The rate for intensive residential treatment services and assertive community treatment  
382.24 must exclude room and board, as defined in section 256I.03, subdivision 6, and services  
382.25 not covered under this section, such as partial hospitalization, home care, and inpatient  
382.26 services.

382.27 (e) Physician services that are not separately billed may be included in the rate to the  
382.28 extent that a psychiatrist, or other health care professional providing physician services  
382.29 within their scope of practice, is a member of the intensive residential treatment services  
382.30 treatment team. Physician services, whether billed separately or included in the rate, may  
382.31 be delivered by telehealth. For purposes of this paragraph, "telehealth" has the meaning  
382.32 given to "mental health telehealth" in section 256B.0625, subdivision 46, when telehealth  
382.33 is used to provide intensive residential treatment services.

383.1 (f) When services under this section are provided by an assertive community treatment  
383.2 provider, case management functions must be an integral part of the team.

383.3 (g) The rate for a provider must not exceed the rate charged by that provider for the  
383.4 same service to other payors.

383.5 (h) The rates for existing programs must be established prospectively based upon the  
383.6 expenditures and utilization over a prior 12-month period using the criteria established in  
383.7 paragraph (c). The rates for new programs must be established based upon estimated  
383.8 expenditures and estimated utilization using the criteria established in paragraph (c).

383.9 (i) Entities who discontinue providing services must be subject to a settle-up process  
383.10 whereby actual costs and reimbursement for the previous 12 months are compared. In the  
383.11 event that the entity was paid more than the entity's actual costs plus any applicable  
383.12 performance-related funding due the provider, the excess payment must be reimbursed to  
383.13 the department. If a provider's revenue is less than actual allowed costs due to lower  
383.14 utilization than projected, the commissioner may reimburse the provider to recover its actual  
383.15 allowable costs. The resulting adjustments by the commissioner must be proportional to the  
383.16 percent of total units of service reimbursed by the commissioner and must reflect a difference  
383.17 of greater than five percent.

383.18 (j) A provider may request of the commissioner a review of any rate-setting decision  
383.19 made under this subdivision.

383.20 Sec. 19. Minnesota Statutes 2022, section 256B.0624, subdivision 5, is amended to read:

383.21 Subd. 5. **Crisis assessment and intervention staff qualifications.** (a) Qualified  
383.22 individual staff of a qualified provider entity must provide crisis assessment and intervention  
383.23 services to a recipient. A staff member providing crisis assessment and intervention services  
383.24 to a recipient must be qualified as a:

383.25 (1) mental health professional;

383.26 (2) clinical trainee;

383.27 (3) mental health practitioner;

383.28 (4) mental health certified family peer specialist; or

383.29 (5) mental health certified peer specialist.

383.30 (b) When crisis assessment and intervention services are provided to a recipient in the  
383.31 community, a mental health professional, clinical trainee, or mental health practitioner must  
383.32 lead the response.

384.1 (c) The 30 hours of ongoing training required by section 245I.05, subdivision 4, paragraph  
384.2 (b), must be specific to providing crisis services to children and adults and include training  
384.3 about evidence-based practices identified by the commissioner of health to reduce the  
384.4 recipient's risk of suicide and self-injurious behavior.

384.5 (d) At least six hours of the ongoing training under paragraph (c) must be specific to  
384.6 working with families and providing crisis stabilization services to children and include the  
384.7 following topics:

384.8 (1) developmental tasks of childhood and adolescence;

384.9 (2) family relationships;

384.10 (3) child and youth engagement and motivation, including motivational interviewing;

384.11 (4) culturally responsive care, including care for lesbian, gay, bisexual, transgender, and  
384.12 queer youth;

384.13 (5) positive behavior support;

384.14 (6) crisis intervention for youth with developmental disabilities;

384.15 (7) child traumatic stress, trauma-informed care, and trauma-focused cognitive behavioral  
384.16 therapy; and

384.17 (8) youth substance use.

384.18 ~~(d)~~ (e) Team members must be experienced in crisis assessment, crisis intervention  
384.19 techniques, treatment engagement strategies, working with families, and clinical  
384.20 decision-making under emergency conditions and have knowledge of local services and  
384.21 resources.

384.22 Sec. 20. Minnesota Statutes 2022, section 256B.0624, subdivision 8, is amended to read:

384.23 Subd. 8. **Crisis stabilization staff qualifications.** (a) Mental health crisis stabilization  
384.24 services must be provided by qualified individual staff of a qualified provider entity. A staff  
384.25 member providing crisis stabilization services to a recipient must be qualified as a:

384.26 (1) mental health professional;

384.27 (2) certified rehabilitation specialist;

384.28 (3) clinical trainee;

384.29 (4) mental health practitioner;

384.30 (5) mental health certified family peer specialist;

385.1 (6) mental health certified peer specialist; or

385.2 (7) mental health rehabilitation worker.

385.3 (b) The 30 hours of ongoing training required in section 245I.05, subdivision 4, paragraph  
385.4 (b), must be specific to providing crisis services to children and adults and include training  
385.5 about evidence-based practices identified by the commissioner of health to reduce a recipient's  
385.6 risk of suicide and self-injurious behavior.

385.7 (c) For providers who deliver care to children 21 years of age and younger, at least six  
385.8 hours of the ongoing training under this subdivision must be specific to working with families  
385.9 and providing crisis stabilization services to children and include the following topics:

385.10 (1) developmental tasks of childhood and adolescence;

385.11 (2) family relationships;

385.12 (3) child and youth engagement and motivation, including motivational interviewing;

385.13 (4) culturally responsive care, including care for lesbian, gay, bisexual, transgender, and  
385.14 queer youth;

385.15 (5) positive behavior support;

385.16 (6) crisis intervention for youth with developmental disabilities;

385.17 (7) child traumatic stress, trauma-informed care, and trauma-focused cognitive behavioral  
385.18 therapy; and

385.19 (8) youth substance use.

385.20 Sec. 21. Minnesota Statutes 2022, section 256B.0941, is amended by adding a subdivision  
385.21 to read:

385.22 Subd. 2b. **Shared site.** Related services that have a bright line separation from psychiatric  
385.23 residential treatment facility service operations may be delivered in the same facility,  
385.24 including under the same structural roof. In shared site settings, staff must provide services  
385.25 only to programs they are affiliated to through NETStudy 2.0.

385.26 Sec. 22. Minnesota Statutes 2022, section 256B.0941, is amended by adding a subdivision  
385.27 to read:

385.28 Subd. 5. **Start-up and capacity-building grants.** (a) The commissioner shall establish  
385.29 start-up and capacity-building grants for psychiatric residential treatment facility sites.

386.1 Start-up grants to prospective psychiatric residential treatment facility sites may be used  
386.2 for:

386.3 (1) administrative expenses;

386.4 (2) consulting services;

386.5 (3) Health Insurance Portability and Accountability Act of 1996 compliance;

386.6 (4) therapeutic resources, including evidence-based, culturally appropriate curriculums  
386.7 and training programs for staff and clients;

386.8 (5) allowable physical renovations to the property; and

386.9 (6) emergency workforce shortage uses, as determined by the commissioner.

386.10 (b) Start-up and capacity-building grants to prospective and current psychiatric residential  
386.11 treatment facilities may be used to support providers who treat and accept individuals with  
386.12 complex support needs, including but not limited to:

386.13 (1) neurocognitive disorders;

386.14 (2) co-occurring intellectual developmental disabilities;

386.15 (3) schizophrenia spectrum disorders;

386.16 (4) manifested or labeled aggressive behaviors; and

386.17 (5) manifested sexually inappropriate behaviors.

386.18 **EFFECTIVE DATE.** This section is effective July 1, 2023.

386.19 Sec. 23. Minnesota Statutes 2022, section 256B.0947, is amended by adding a subdivision  
386.20 to read:

386.21 Subd. 10. **Young adult continuity of care.** A client who received services under this  
386.22 section or section 256B.0946 and aged out of eligibility may continue to receive services  
386.23 from the same providers under this section until the client is 27 years old.

386.24 Sec. 24. Minnesota Statutes 2022, section 256B.761, is amended to read:

386.25 **256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.**

386.26 (a) Effective for services rendered on or after July 1, 2001, payment for medication  
386.27 management provided to psychiatric patients, outpatient mental health services, day treatment  
386.28 services, home-based mental health services, and family community support services shall

387.1 be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of  
387.2 1999 charges.

387.3 (b) Effective July 1, 2001, the medical assistance rates for outpatient mental health  
387.4 services provided by an entity that operates: (1) a Medicare-certified comprehensive  
387.5 outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1, 1993,  
387.6 with at least 33 percent of the clients receiving rehabilitation services in the most recent  
387.7 calendar year who are medical assistance recipients, will be increased by 38 percent, when  
387.8 those services are provided within the comprehensive outpatient rehabilitation facility and  
387.9 provided to residents of nursing facilities owned by the entity.

387.10 (c) In addition to rate increases otherwise provided, the commissioner may restructure  
387.11 coverage policy and rates to improve access to adult rehabilitative mental health services  
387.12 under section 256B.0623 and related mental health support services under section 256B.021,  
387.13 subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and 2016, the projected  
387.14 state share of increased costs due to this paragraph is transferred from adult mental health  
387.15 grants under sections 245.4661 and 256E.12. The transfer for fiscal year 2016 is a permanent  
387.16 base adjustment for subsequent fiscal years. Payments made to managed care plans and  
387.17 county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect  
387.18 the rate changes described in this paragraph.

387.19 (d) Any ratables effective before July 1, 2015, do not apply to early intensive  
387.20 developmental and behavioral intervention (EIDBI) benefits described in section 256B.0949.

387.21 (e) Effective for services rendered on or after January 1, 2024, payment rates for  
387.22 behavioral health services included in the rate analysis required by Laws 2021, First Special  
387.23 Session chapter 7, article 17, section 18, must be increased by four percent from the rates  
387.24 in effect on December 31, 2023. This paragraph does not apply to federally qualified health  
387.25 centers, rural health centers, Indian health services, certified community behavioral health  
387.26 clinics, cost-based rates, and rates that are negotiated with the county. This paragraph expires  
387.27 upon legislative implementation of the new rate methodology resulting from the rate analysis  
387.28 required by Laws 2021, First Special Session chapter 7, article 17, section 18.

387.29 (f) Effective January 1, 2024, the commissioner shall increase capitation payments made  
387.30 to managed care plans and county-based purchasing plans to reflect the behavioral health  
387.31 service rate increase provided in paragraph (e). Managed care and county-based purchasing  
387.32 plans must use the capitation rate increase provided under this paragraph to increase payment  
387.33 rates to behavioral health services providers. The commissioner must monitor the effect of  
387.34 this rate increase on enrollee access to behavioral health services. If, for any contract year,

388.1 federal approval is not received for this paragraph, the commissioner must adjust the  
388.2 capitation rates paid to managed care plans and county-based purchasing plans for that  
388.3 contract year to reflect the removal of this provision. Contracts between managed care plans  
388.4 and county-based purchasing plans and providers to whom this paragraph applies must  
388.5 allow recovery of payments from those providers if capitation rates are adjusted in accordance  
388.6 with this paragraph. Payment recoveries must not exceed the amount equal to any increase  
388.7 in rates that results from this provision.

388.8 **Sec. 25. LOCAL AGENCY SUBSTANCE USE DISORDER ALLOCATION.**

388.9 The commissioner of human services shall evaluate the ongoing need for local agency  
388.10 substance use disorder allocations under section 254B.02. The evaluation must include  
388.11 recommendations on whether local agency allocations should continue, and if so, must  
388.12 recommend what the purpose of the allocations should be and propose an updated allocation  
388.13 methodology that aligns with the purpose and person-centered outcomes for people  
388.14 experiencing substance use disorders and behavioral health conditions. The commissioner  
388.15 may contract with a vendor to support this evaluation through research and actuarial analysis.

388.16 **EFFECTIVE DATE.** This section is effective the day following final enactment.

388.17 **Sec. 26. RATE INCREASE FOR MENTAL HEALTH ADULT DAY TREATMENT.**

388.18 The commissioner of human services must increase the reimbursement rate for adult  
388.19 day treatment under Minnesota Statutes, section 256B.0671, subdivision 3, by 50 percent  
388.20 over the reimbursement rate in effect as of June 30, 2023.

388.21 **EFFECTIVE DATE.** This section is effective January 1, 2024, or upon federal approval,  
388.22 whichever is later. The commissioner of human services shall notify the revisor of statutes  
388.23 when federal approval is obtained.

388.24 **Sec. 27. ROOM AND BOARD COSTS IN CHILDREN'S RESIDENTIAL**  
388.25 **FACILITIES.**

388.26 The commissioner of human services must update the behavioral health fund room and  
388.27 board rate schedule to include services provided under Minnesota Statutes, section 245.4882,  
388.28 for individuals who do not have a placement under Minnesota Statutes, chapter 260C or  
388.29 260D. The commissioner must establish room and board rates commensurate with current  
388.30 room and board rates for adolescent programs licensed under Minnesota Statutes, section  
388.31 245G.18.

388.32 **EFFECTIVE DATE.** This section is effective July 1, 2023.

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## ARTICLE 8

### DEPARTMENT OF HUMAN SERVICES POLICY

Section 1. Minnesota Statutes 2022, section 245.4661, subdivision 9, is amended to read:

Subd. 9. **Services and programs.** (a) The following three distinct grant programs are funded under this section:

- (1) mental health crisis services;
- (2) housing with supports for adults with serious mental illness; and
- (3) projects for assistance in transitioning from homelessness (PATH program).

(b) In addition, the following are eligible for grant funds:

- (1) community education and prevention;
- (2) client outreach;
- (3) early identification and intervention;
- (4) adult outpatient diagnostic assessment and psychological testing;
- (5) peer support services;
- (6) community support program services (CSP);
- (7) adult residential crisis stabilization;
- (8) supported employment;
- (9) assertive community treatment (ACT);
- (10) housing subsidies;
- (11) basic living, social skills, and community intervention;
- (12) emergency response services;
- (13) adult outpatient psychotherapy;
- (14) adult outpatient medication management;
- (15) adult mobile crisis services;
- (16) adult day treatment;
- (17) partial hospitalization;
- (18) adult residential treatment;
- (19) adult mental health targeted case management; and

390.1 ~~(20) intensive community rehabilitative services (ICRS); and~~

390.2 ~~(21)~~ (20) transportation.

390.3 Sec. 2. Minnesota Statutes 2022, section 245.469, subdivision 3, is amended to read:

390.4 Subd. 3. **Mental health crisis services.** The commissioner of human services shall  
390.5 increase access to mental health crisis services for children and adults. In order to increase  
390.6 access, the commissioner must:

390.7 (1) develop a central phone number where calls can be routed to the appropriate crisis  
390.8 services;

390.9 (2) provide telephone consultation 24 hours a day to mobile crisis teams who are serving  
390.10 people with traumatic brain injury or intellectual disabilities who are experiencing a mental  
390.11 health crisis;

390.12 (3) expand crisis services across the state, including rural areas of the state and examining  
390.13 access per population;

390.14 (4) establish and implement state standards and requirements for crisis services as outlined  
390.15 in section 256B.0624; and

390.16 (5) provide grants to adult mental health initiatives, counties, tribes, or community mental  
390.17 health providers to establish new mental health crisis residential service capacity.

390.18 Priority will be given to regions that do not have a mental health crisis residential services  
390.19 program, do not have an inpatient psychiatric unit within the region, do not have an inpatient  
390.20 psychiatric unit within 90 miles, or have a demonstrated need based on the number of crisis  
390.21 residential or intensive residential treatment beds available to meet the needs of the residents  
390.22 in the region. At least 50 percent of the funds must be distributed to programs in rural  
390.23 Minnesota. Grant funds may be used for start-up costs, including but not limited to  
390.24 renovations, furnishings, and staff training. Grant applications shall provide details on how  
390.25 the intended service will address identified needs and shall demonstrate collaboration with  
390.26 crisis teams, other mental health providers, hospitals, and police.

390.27 **EFFECTIVE DATE.** This section is effective the day following final enactment.

390.28 Sec. 3. **[245.4903] CULTURAL AND ETHNIC MINORITY INFRASTRUCTURE**  
390.29 **GRANT PROGRAM.**

390.30 **Subdivision 1. Establishment.** The commissioner of human services shall establish a  
390.31 cultural and ethnic minority infrastructure grant program to ensure that mental health and

391.1 substance use disorder treatment supports and services are culturally specific and culturally  
391.2 responsive to meet the cultural needs of the communities served.

391.3 Subd. 2. **Eligible applicants.** An eligible applicant is a licensed entity or provider from  
391.4 a cultural or ethnic minority population who:

391.5 (1) provides mental health or substance use disorder treatment services and supports to  
391.6 individuals from cultural and ethnic minority populations, including individuals who are  
391.7 lesbian, gay, bisexual, transgender, or queer and from cultural and ethnic minority  
391.8 populations;

391.9 (2) provides or is qualified and has the capacity to provide clinical supervision and  
391.10 support to members of culturally diverse and ethnic minority communities to qualify as  
391.11 mental health and substance use disorder treatment providers; or

391.12 (3) has the capacity and experience to provide training for mental health and substance  
391.13 use disorder treatment providers on cultural competency and cultural humility.

391.14 Subd. 2. **Allowable grant activities.** (a) The cultural and ethnic minority infrastructure  
391.15 grant program grantees must engage in activities and provide supportive services to ensure  
391.16 and increase equitable access to culturally specific and responsive care and to build  
391.17 organizational and professional capacity for licensure and certification for the communities  
391.18 served. Allowable grant activities include but are not limited to:

391.19 (1) workforce development activities focused on recruiting, supporting, training, and  
391.20 supervision activities for mental health and substance use disorder practitioners and  
391.21 professionals from diverse racial, cultural, and ethnic communities;

391.22 (2) supporting members of culturally diverse and ethnic minority communities to qualify  
391.23 as mental health and substance use disorder professionals, practitioners, clinical supervisors,  
391.24 recovery peer specialists, mental health certified peer specialists, and mental health certified  
391.25 family peer specialists;

391.26 (3) culturally specific outreach, early intervention, trauma-informed services, and recovery  
391.27 support in mental health and substance use disorder services;

391.28 (4) provision of trauma-informed, culturally responsive mental health and substance use  
391.29 disorder supports and services for children and families, youth, or adults who are from  
391.30 cultural and ethnic minority backgrounds and are uninsured or underinsured;

391.31 (5) mental health and substance use disorder service expansion and infrastructure  
391.32 improvement activities, particularly in greater Minnesota;

392.1 (6) training for mental health and substance use disorder treatment providers on cultural  
392.2 competency and cultural humility;

392.3 (7) activities to increase the availability of culturally responsive mental health and  
392.4 substance use disorder services for children and families, youth, or adults or to increase the  
392.5 availability of substance use disorder services for individuals from cultural and ethnic  
392.6 minorities in the state; and

392.7 (8) providing interpreter services at intensive residential treatment facilities, children's  
392.8 residential treatment centers, or psychiatric residential treatment facilities in order for  
392.9 children or adults with limited English proficiency or for children or adults who are fluent  
392.10 in another language to be able to access treatment.

392.11 (b) The commissioner must assist grantees with meeting third-party credentialing  
392.12 requirements, and grantees must obtain all available third-party reimbursement sources as  
392.13 a condition of receiving grant funds. Grantees must serve individuals from cultural and  
392.14 ethnic minority communities regardless of health coverage status or ability to pay.

392.15 Subd. 3. **Data collection and outcomes.** Grantees must provide regular data summaries  
392.16 to the commissioner for purposes of evaluating the effectiveness of the cultural and ethnic  
392.17 minority infrastructure grant program. The commissioner must use identified culturally  
392.18 appropriate outcome measures instruments to evaluate outcomes and must evaluate program  
392.19 activities by analyzing whether the program:

392.20 (1) increased access to culturally specific services for individuals from cultural and  
392.21 ethnic minority communities across the state;

392.22 (2) increased the number of individuals from cultural and ethnic minority communities  
392.23 served by grantees;

392.24 (3) increased cultural responsiveness and cultural competency of mental health and  
392.25 substance use disorder treatment providers;

392.26 (4) increased the number of mental health and substance use disorder treatment providers  
392.27 and clinical supervisors from cultural and ethnic minority communities;

392.28 (5) increased the number of mental health and substance use disorder treatment  
392.29 organizations owned, managed, or led by individuals who are Black, Indigenous, or people  
392.30 of color;

392.31 (6) reduced health disparities through improved clinical and functional outcomes for  
392.32 those accessing services; and

393.1 (7) led to an overall increase in culturally specific mental health and substance use  
393.2 disorder service availability.

393.3 **EFFECTIVE DATE.** This section is effective the day following final enactment.

393.4 Sec. 4. **[245.4906] MENTAL HEALTH CERTIFIED PEER SPECIALIST GRANT**  
393.5 **PROGRAM.**

393.6 Subdivision 1. **Establishment.** The mental health certified peer specialist grant program  
393.7 is established in the Department of Human Services to provide funding for training for  
393.8 mental health certified peer specialists who provide services to support individuals with  
393.9 lived experience of mental illness under section 256B.0615. Certified peer specialists provide  
393.10 services to individuals who are receiving assertive community treatment or intensive  
393.11 residential treatment services under section 256B.0622, adult rehabilitative mental health  
393.12 services under section 256B.0623, or crisis response services under section 256B.0624.  
393.13 Mental health certified peer specialist qualifications are defined in section 245I.04,  
393.14 subdivision 10, and mental health certified peer specialists' scope of practice is defined in  
393.15 section 245I.04, subdivision 11.

393.16 Subd. 2. **Activities.** Grant funding may be used to provide training for mental health  
393.17 certified peer specialists as specified in section 256B.0615, subdivision 5.

393.18 Subd. 3. **Outcomes.** Evaluation includes the extent to which individuals receiving peer  
393.19 services:

393.20 (1) experience progress on achieving treatment goals; and

393.21 (2) experience a reduction in hospital admissions.

393.22 **EFFECTIVE DATE.** This section is effective the day following final enactment.

393.23 Sec. 5. **[245.4907] MENTAL HEALTH CERTIFIED FAMILY PEER SPECIALIST**  
393.24 **GRANT PROGRAM.**

393.25 Subdivision 1. **Establishment.** The mental health certified peer family specialist grant  
393.26 program is established in the Department of Human Services to provide funding for training  
393.27 for mental health certified peer family specialists who provide services to support individuals  
393.28 with lived experience of mental illness under section 256B.0616. Certified family peer  
393.29 specialists provide services to families who have a child with an emotional disturbance or  
393.30 severe emotional disturbance under chapter 245. Certified family peer specialists provide  
393.31 services to families whose children are receiving inpatient hospitalization under section  
393.32 256B.0625, subdivision 1; partial hospitalization under Minnesota Rules, parts 9505.0370,

394.1 subpart 24, and 9505.0372, subpart 9; residential treatment under section 245.4882; children's  
394.2 intensive behavioral health services under section 256B.0946; and day treatment, children's  
394.3 therapeutic services and supports, or crisis response services under section 256B.0624.  
394.4 Mental health certified family peer specialist qualifications are defined in section 245I.04,  
394.5 subdivision 12, and mental health certified family peer specialists' scope of practice is  
394.6 defined in section 245I.04, subdivision 13.

394.7 Subd. 2. **Activities.** Grant funding may be used to provide training for mental health  
394.8 certified family peer specialists as specified in section 256B.0616, subdivision 5.

394.9 Subd. 3. **Outcomes.** Evaluation includes the extent to which individuals receiving family  
394.10 peer services:

394.11 (1) progress on achieving treatment goals; and

394.12 (2) experience a reduction in hospital admissions.

394.13 **EFFECTIVE DATE.** This section is effective the day following final enactment.

394.14 Sec. 6. **[245.991] PROJECTS FOR ASSISTANCE IN TRANSITION FROM**  
394.15 **HOMELESSNESS PROGRAM.**

394.16 Subdivision 1. **Establishment.** The projects for assistance in transition from homelessness  
394.17 program is established in the Department of Human Services to prevent or end homelessness  
394.18 for people with serious mental illness or co-occurring substance use disorder and ensure  
394.19 the commissioner may achieve the goals of the housing mission statement in section 245.461,  
394.20 subdivision 4.

394.21 Subd. 2. **Activities.** All projects for assistance in transition from homelessness must  
394.22 provide homeless outreach and case management services. Projects may provide clinical  
394.23 assessment, habilitation and rehabilitation services, community mental health services,  
394.24 substance use disorder treatment, housing transition and sustaining services, direct assistance  
394.25 funding, and other activities as determined by the commissioner.

394.26 Subd. 3. **Eligibility.** Program activities must be provided to people with serious mental  
394.27 illness, or with co-occurring substance use disorder, who meet homeless criteria determined  
394.28 by the commissioner. People receiving homeless outreach may be presumed eligible until  
394.29 serious mental illness can be verified.

394.30 Subd. 4. **Outcomes.** Evaluation of each project includes the extent to which:

394.31 (1) grantees contact individuals through homeless outreach services;

394.32 (2) grantees enroll individuals in case management services;

395.1 (3) individuals access behavioral health services; and

395.2 (4) individuals transition from homelessness to housing.

395.3 Subd. 5. **Federal aid or grants.** The commissioner of human services must comply with  
395.4 all conditions and requirements necessary to receive federal aid or grants with respect to  
395.5 homeless services or programs as specified in section 245.70.

395.6 **EFFECTIVE DATE.** This section is effective the day following final enactment.

395.7 Sec. 7. **[245.992] HOUSING WITH SUPPORT FOR ADULTS WITH SERIOUS**  
395.8 **MENTAL ILLNESS PROGRAM.**

395.9 Subdivision 1. **Creation.** The housing with support for adults with serious mental illness  
395.10 program is established in the Department of Human Services to prevent or end homelessness  
395.11 for people with serious mental illness, increase the availability of housing with support, and  
395.12 ensure the commissioner may achieve the goals of the housing mission statement in section  
395.13 245.461, subdivision 4.

395.14 Subd. 2. **Activities.** The housing with support for adults with serious mental illness  
395.15 program may provide a range of activities and supportive services to assure that people  
395.16 obtain and retain permanent supportive housing. Program activities may include case  
395.17 management, site-based housing services, housing transition and sustaining services, outreach  
395.18 services, community support services, direct assistance funding, and other activities as  
395.19 determined by the commissioner.

395.20 Subd. 3. **Eligibility.** Program activities must be provided to people with serious mental  
395.21 illness, or with co-occurring substance use disorder, who meet homeless criteria determined  
395.22 by the commissioner.

395.23 Subd. 4. **Outcomes.** Evaluation of program activities must utilize evidence-based  
395.24 practices and must include the extent to which:

395.25 (1) grantees' housing and activities utilize evidence-based practices;

395.26 (2) individuals transition from homelessness to housing;

395.27 (3) individuals retain housing; and

395.28 (4) individuals are satisfied with their housing.

395.29 **EFFECTIVE DATE.** This section is effective the day following final enactment.

396.1 Sec. 8. Minnesota Statutes 2022, section 256.478, is amended by adding a subdivision to  
396.2 read:

396.3 Subd. 3. **Authorized uses of grant funds.** Grant funds may be used for but are not  
396.4 limited to the following:

396.5 (1) increasing access to home and community-based services for an individual;

396.6 (2) improving caregiver-child relationships and aiding progress toward treatment goals;  
396.7 and

396.8 (3) reducing emergency department visits.

396.9 **EFFECTIVE DATE.** This section is effective the day following final enactment.

396.10 Sec. 9. Minnesota Statutes 2022, section 256.478, is amended by adding a subdivision to  
396.11 read:

396.12 Subd. 4. **Outcomes.** Program evaluation is based on but not limited to the following  
396.13 criteria:

396.14 (1) expediting discharges for individuals who no longer need hospital level of care;

396.15 (2) individuals obtaining and retaining housing;

396.16 (3) individuals maintaining community living by diverting admission to Anoka Metro  
396.17 Regional Treatment Center and Forensic Mental Health Program;

396.18 (4) reducing recidivism rates of individuals returning to state institutions; and

396.19 (5) individuals' ability to live in the least restrictive community setting.

396.20 **EFFECTIVE DATE.** This section is effective the day following final enactment.

396.21 Sec. 10. Minnesota Statutes 2022, section 256B.056, is amended by adding a subdivision  
396.22 to read:

396.23 Subd. 5d. **Medical assistance room and board rate.** "Medical assistance room and  
396.24 board rate" means an amount equal to 81 percent of the federal poverty guideline for a single  
396.25 individual living alone in the community less the medical assistance personal needs allowance  
396.26 under section 256B.35. The amount of the room and board rate, as defined in section 256I.03,  
396.27 subdivision 2, that exceeds the medical assistance room and board rate is considered a  
396.28 remedial care cost. A remedial care cost may be used to meet a spenddown obligation under  
396.29 this section. The medical assistance room and board rate is to be adjusted on January 1 of  
396.30 each year.

397.1 Sec. 11. Minnesota Statutes 2022, section 256B.0622, subdivision 8, is amended to read:

397.2 Subd. 8. **Medical assistance payment for assertive community treatment and**  
397.3 **intensive residential treatment services.** (a) Payment for intensive residential treatment  
397.4 services and assertive community treatment in this section shall be based on one daily rate  
397.5 per provider inclusive of the following services received by an eligible client in a given  
397.6 calendar day: all rehabilitative services under this section, staff travel time to provide  
397.7 rehabilitative services under this section, and nonresidential crisis stabilization services  
397.8 under section 256B.0624.

397.9 (b) Except as indicated in paragraph (c), payment will not be made to more than one  
397.10 entity for each client for services provided under this section on a given day. If services  
397.11 under this section are provided by a team that includes staff from more than one entity, the  
397.12 team must determine how to distribute the payment among the members.

397.13 (c) The commissioner shall determine one rate for each provider that will bill medical  
397.14 assistance for residential services under this section and one rate for each assertive community  
397.15 treatment provider. If a single entity provides both services, one rate is established for the  
397.16 entity's residential services and another rate for the entity's nonresidential services under  
397.17 this section. A provider is not eligible for payment under this section without authorization  
397.18 from the commissioner. The commissioner shall develop rates using the following criteria:

397.19 (1) the provider's cost for services shall include direct services costs, other program  
397.20 costs, and other costs determined as follows:

397.21 (i) the direct services costs must be determined using actual costs of salaries, benefits,  
397.22 payroll taxes, and training of direct service staff and service-related transportation;

397.23 (ii) other program costs not included in item (i) must be determined as a specified  
397.24 percentage of the direct services costs as determined by item (i). The percentage used shall  
397.25 be determined by the commissioner based upon the average of percentages that represent  
397.26 the relationship of other program costs to direct services costs among the entities that provide  
397.27 similar services;

397.28 (iii) physical plant costs calculated based on the percentage of space within the program  
397.29 that is entirely devoted to treatment and programming. This does not include administrative  
397.30 or residential space;

397.31 (iv) assertive community treatment physical plant costs must be reimbursed as part of  
397.32 the costs described in item (ii); and

398.1 (v) subject to federal approval, up to an additional five percent of the total rate may be  
398.2 added to the program rate as a quality incentive based upon the entity meeting performance  
398.3 criteria specified by the commissioner;

398.4 (2) actual cost is defined as costs which are allowable, allocable, and reasonable, and  
398.5 consistent with federal reimbursement requirements under Code of Federal Regulations,  
398.6 title 48, chapter 1, part 31, relating to for-profit entities, and Office of Management and  
398.7 Budget Circular Number A-122, relating to nonprofit entities;

398.8 (3) the number of service units;

398.9 (4) the degree to which clients will receive services other than services under this section;  
398.10 and

398.11 (5) the costs of other services that will be separately reimbursed.

398.12 (d) The rate for intensive residential treatment services and assertive community treatment  
398.13 must exclude the medical assistance room and board rate, as defined in section ~~256I.03~~,  
398.14 ~~subdivision 6~~ 256B.056, subdivision 5d, and services not covered under this section, such  
398.15 as partial hospitalization, home care, and inpatient services.

398.16 (e) Physician services that are not separately billed may be included in the rate to the  
398.17 extent that a psychiatrist, or other health care professional providing physician services  
398.18 within their scope of practice, is a member of the intensive residential treatment services  
398.19 treatment team. Physician services, whether billed separately or included in the rate, may  
398.20 be delivered by telehealth. For purposes of this paragraph, "telehealth" has the meaning  
398.21 given to "mental health telehealth" in section 256B.0625, subdivision 46, when telehealth  
398.22 is used to provide intensive residential treatment services.

398.23 (f) When services under this section are provided by an assertive community treatment  
398.24 provider, case management functions must be an integral part of the team.

398.25 (g) The rate for a provider must not exceed the rate charged by that provider for the  
398.26 same service to other payors.

398.27 (h) The rates for existing programs must be established prospectively based upon the  
398.28 expenditures and utilization over a prior 12-month period using the criteria established in  
398.29 paragraph (c). The rates for new programs must be established based upon estimated  
398.30 expenditures and estimated utilization using the criteria established in paragraph (c).

398.31 (i) Entities who discontinue providing services must be subject to a settle-up process  
398.32 whereby actual costs and reimbursement for the previous 12 months are compared. In the  
398.33 event that the entity was paid more than the entity's actual costs plus any applicable

399.1 performance-related funding due the provider, the excess payment must be reimbursed to  
399.2 the department. If a provider's revenue is less than actual allowed costs due to lower  
399.3 utilization than projected, the commissioner may reimburse the provider to recover its actual  
399.4 allowable costs. The resulting adjustments by the commissioner must be proportional to the  
399.5 percent of total units of service reimbursed by the commissioner and must reflect a difference  
399.6 of greater than five percent.

399.7 (j) A provider may request of the commissioner a review of any rate-setting decision  
399.8 made under this subdivision.

399.9 Sec. 12. Minnesota Statutes 2022, section 256B.0946, subdivision 6, is amended to read:

399.10 Subd. 6. **Excluded services.** (a) Services in clauses (1) to (7) are not covered under this  
399.11 section and are not eligible for medical assistance payment as components of children's  
399.12 intensive behavioral health services, but may be billed separately:

399.13 (1) inpatient psychiatric hospital treatment;

399.14 (2) mental health targeted case management;

399.15 (3) partial hospitalization;

399.16 (4) medication management;

399.17 (5) children's mental health day treatment services;

399.18 (6) crisis response services under section 256B.0624;

399.19 (7) transportation; and

399.20 (8) mental health certified family peer specialist services under section 256B.0616.

399.21 (b) Children receiving intensive behavioral health services are not eligible for medical  
399.22 assistance reimbursement for the following services while receiving children's intensive  
399.23 behavioral health services:

399.24 (1) psychotherapy and skills training components of children's therapeutic services and  
399.25 supports under section 256B.0943;

399.26 (2) mental health behavioral aide services as defined in section 256B.0943, subdivision  
399.27 1, paragraph (l);

399.28 (3) home and community-based waiver services;

399.29 (4) mental health residential treatment; and

400.1 (5) medical assistance room and board costs rate, as defined in section ~~256I.03~~,  
400.2 ~~subdivision 6~~ 256B.056, subdivision 5d.

400.3 Sec. 13. Minnesota Statutes 2022, section 256B.0947, subdivision 7a, is amended to read:

400.4 Subd. 7a. **Noncovered services.** (a) The rate for intensive rehabilitative mental health  
400.5 services does not include medical assistance payment for services in clauses (1) to (7).  
400.6 Services not covered under this paragraph may be billed separately:

400.7 (1) inpatient psychiatric hospital treatment;

400.8 (2) partial hospitalization;

400.9 (3) children's mental health day treatment services;

400.10 (4) physician services outside of care provided by a psychiatrist serving as a member of  
400.11 the treatment team;

400.12 (5) medical assistance room and board costs rate, as defined in section ~~256I.03~~,  
400.13 ~~subdivision 6~~ 256B.056, subdivision 5d;

400.14 (6) home and community-based waiver services; and

400.15 (7) other mental health services identified in the child's individualized education program.

400.16 (b) The following services are not covered under this section and are not eligible for  
400.17 medical assistance payment while youth are receiving intensive rehabilitative mental health  
400.18 services:

400.19 (1) mental health residential treatment; and

400.20 (2) mental health behavioral aide services, as defined in section 256B.0943, subdivision  
400.21 1, paragraph (l).

400.22 Sec. 14. Minnesota Statutes 2022, section 256D.02, is amended by adding a subdivision  
400.23 to read:

400.24 Subd. 20. **Date of application.** "Date of application" has the meaning given in section  
400.25 256P.01, subdivision 2b.

400.26 Sec. 15. Minnesota Statutes 2022, section 256D.07, is amended to read:

400.27 **256D.07 TIME OF PAYMENT OF ASSISTANCE.**

400.28 An applicant for general assistance shall be deemed eligible if the application and the  
400.29 verification of the statement on that application demonstrate that the applicant is within the

401.1 eligibility criteria established by sections 256D.01 to 256D.21 and any applicable rules of  
401.2 the commissioner. Any person requesting general assistance shall be permitted by the county  
401.3 agency to make an application for assistance as soon as administratively possible and in no  
401.4 event later than the fourth day following the date on which assistance is first requested, and  
401.5 no county agency shall require that a person requesting assistance appear at the offices of  
401.6 the county agency more than once prior to the date on which the person is permitted to make  
401.7 the application. ~~The application shall be in writing in the manner and upon the form~~  
401.8 ~~prescribed by the commissioner and attested to by the oath of the applicant or in lieu thereof~~  
401.9 ~~shall contain the following declaration which shall be signed by the applicant: "I declare~~  
401.10 ~~that this application has been examined by me and to the best of my knowledge and belief~~  
401.11 ~~is a true and correct statement of every material point."~~ Applications must be submitted  
401.12 according to section 256P.04, subdivision 1a. On the date that general assistance is first  
401.13 requested, the county agency shall inquire and determine whether the person requesting  
401.14 assistance is in immediate need of food, shelter, clothing, assistance for necessary  
401.15 transportation, or other emergency assistance pursuant to section 256D.06, subdivision 2.  
401.16 A person in need of emergency assistance shall be granted emergency assistance immediately,  
401.17 and necessary emergency assistance shall continue for up to 30 days following the date of  
401.18 application. A determination of an applicant's eligibility for general assistance shall be made  
401.19 by the county agency as soon as the required verifications are received by the county agency  
401.20 and in no event later than 30 days following the date that the application is made. Any  
401.21 verifications required of the applicant shall be reasonable, and the commissioner shall by  
401.22 rule establish reasonable verifications. General assistance shall be granted to an eligible  
401.23 applicant without the necessity of first securing action by the board of the county agency.  
401.24 The first month's grant must be computed to cover the time period starting with the date a  
401.25 ~~signed application form is received by the county agency~~ of application, as defined by  
401.26 section 256P.01, subdivision 2b, or from the date that the applicant meets all eligibility  
401.27 factors, whichever occurs later.

401.28 If upon verification and due investigation it appears that the applicant provided false  
401.29 information and the false information materially affected the applicant's eligibility for general  
401.30 assistance or the amount of the applicant's general assistance grant, the county agency may  
401.31 refer the matter to the county attorney. The county attorney may commence a criminal  
401.32 prosecution or a civil action for the recovery of any general assistance wrongfully received,  
401.33 or both.

402.1 Sec. 16. Minnesota Statutes 2022, section 256I.03, subdivision 15, is amended to read:

402.2 Subd. 15. **Supportive housing.** "Supportive housing" means housing that is not  
402.3 time-limited ~~and~~, provides or coordinates services necessary for a resident to maintain  
402.4 housing stability, and is not licensed as an assisted living facility under chapter 144G.

402.5 Sec. 17. Minnesota Statutes 2022, section 256I.03, is amended by adding a subdivision  
402.6 to read:

402.7 Subd. 16. **Date of application.** "Date of application" has the meaning given in section  
402.8 256P.01, subdivision 2b.

402.9 Sec. 18. Minnesota Statutes 2022, section 256I.04, subdivision 2, is amended to read:

402.10 Subd. 2. **Date of eligibility.** An individual who has met the eligibility requirements of  
402.11 subdivision 1, shall have a housing support payment made on the individual's behalf from  
402.12 the first day of the month ~~in which a signed~~ of the date of application form is received by  
402.13 ~~a county agency,~~ as defined by section 256P.01, subdivision 2b, or the first day of the month  
402.14 in which all eligibility factors have been met, whichever is later.

402.15 Sec. 19. Minnesota Statutes 2022, section 256I.06, subdivision 3, is amended to read:

402.16 Subd. 3. **Filing of application.** ~~The county agency must immediately provide an~~  
402.17 ~~application form to any person requesting housing support. Application for housing support~~  
402.18 ~~must be in writing on a form prescribed by the commissioner. Applications must be submitted~~  
402.19 according to section 256P.04, subdivision 1a. The county agency must determine an  
402.20 applicant's eligibility for housing support as soon as the required verifications are received  
402.21 by the county agency and within 30 days after a signed application is received by the county  
402.22 agency for the aged or blind or within 60 days for people with a disability.

402.23 Sec. 20. Minnesota Statutes 2022, section 256I.09, is amended to read:

402.24 **256I.09 COMMUNITY LIVING INFRASTRUCTURE.**

402.25 The commissioner shall award grants to agencies and multi-Tribal collaboratives through  
402.26 an annual competitive process. Grants awarded under this section may be used for: (1)  
402.27 outreach to locate and engage people who are homeless or residing in segregated settings  
402.28 to screen for basic needs and assist with referral to community living resources; (2) building  
402.29 capacity to provide technical assistance and consultation on housing and related support  
402.30 service resources for persons with both disabilities and low income; or (3) streamlining the

403.1 administration and monitoring activities related to housing support funds. Agencies may  
403.2 collaborate and submit a joint application for funding under this section.

403.3 Sec. 21. Minnesota Statutes 2022, section 256J.08, subdivision 21, is amended to read:

403.4 Subd. 21. **Date of application.** "Date of application" ~~means the date on which the county~~  
403.5 ~~agency receives an applicant's application as a signed written application, an application~~  
403.6 ~~submitted by telephone, or an application submitted through Internet telepresence~~ has the  
403.7 meaning given in section 256P.01, subdivision 2b.

403.8 Sec. 22. Minnesota Statutes 2022, section 256J.09, subdivision 3, is amended to read:

403.9 Subd. 3. **Submitting application form.** (a) A county agency must offer, in person or  
403.10 by mail, the application forms prescribed by the commissioner as soon as a person makes  
403.11 a written or oral inquiry. At that time, the county agency must:

403.12 (1) inform the person that assistance begins on the date ~~that the~~ of application is received  
403.13 ~~by the county agency either as a signed written application; an application submitted by~~  
403.14 ~~telephone; or an application submitted through Internet telepresence;~~, as defined in section  
403.15 256P.01, subdivision 2b, or on the date that all eligibility criteria are met, whichever is later;

403.16 (2) inform a person that the person may submit the application by telephone or through  
403.17 Internet telepresence;

403.18 (3) inform a person ~~that when the person submits the application by telephone or through~~  
403.19 ~~Internet telepresence, the county agency must receive a signed written application within~~  
403.20 ~~30 days of the date that the person submitted the application by telephone or through Internet~~  
403.21 ~~telepresence~~ of the application submission requirements in section 256P.04, subdivision  
403.22 1a;

403.23 (4) inform the person that any delay in submitting the application will reduce the amount  
403.24 of assistance paid for the month of application;

403.25 (5) inform a person that the person may submit the application before an interview;

403.26 (6) explain the information that will be verified during the application process by the  
403.27 county agency as provided in section 256J.32;

403.28 (7) inform a person about the county agency's average application processing time and  
403.29 explain how the application will be processed under subdivision 5;

403.30 (8) explain how to contact the county agency if a person's application information changes  
403.31 and how to withdraw the application;

404.1 (9) inform a person that the next step in the application process is an interview and what  
404.2 a person must do if the application is approved including, but not limited to, attending  
404.3 orientation under section 256J.45 and complying with employment and training services  
404.4 requirements in sections 256J.515 to 256J.57;

404.5 (10) inform the person that an interview must be conducted. The interview may be  
404.6 conducted face-to-face in the county office or at a location mutually agreed upon, through  
404.7 Internet telepresence, or by telephone;

404.8 (11) explain the child care and transportation services that are available under paragraph  
404.9 (c) to enable caregivers to attend the interview, screening, and orientation; and

404.10 (12) identify any language barriers and arrange for translation assistance during  
404.11 appointments, including, but not limited to, screening under subdivision 3a, orientation  
404.12 under section 256J.45, and assessment under section 256J.521.

404.13 (b) Upon receipt of a signed application, the county agency must stamp the date of receipt  
404.14 on the face of the application. The county agency must process the application within the  
404.15 time period required under subdivision 5. An applicant may withdraw the application at  
404.16 any time by giving written or oral notice to the county agency. The county agency must  
404.17 issue a written notice confirming the withdrawal. The notice must inform the applicant of  
404.18 the county agency's understanding that the applicant has withdrawn the application and no  
404.19 longer wants to pursue it. When, within ten days of the date of the agency's notice, an  
404.20 applicant informs a county agency, in writing, that the applicant does not wish to withdraw  
404.21 the application, the county agency must reinstate the application and finish processing the  
404.22 application.

404.23 (c) Upon a participant's request, the county agency must arrange for transportation and  
404.24 child care or reimburse the participant for transportation and child care expenses necessary  
404.25 to enable participants to attend the screening under subdivision 3a and orientation under  
404.26 section 256J.45.

404.27 Sec. 23. Minnesota Statutes 2022, section 256J.95, subdivision 5, is amended to read:

404.28 Subd. 5. **Submitting application form.** The eligibility date for the diversionary work  
404.29 program begins on the date ~~that the combined~~ of application form (CAF) is received by the  
404.30 county agency ~~either as a signed written application; an application submitted by telephone;~~  
404.31 ~~or an application submitted through Internet telepresence;~~ as defined in section 256P.01,  
404.32 subdivision 2b, or on the date that diversionary work program eligibility criteria are met,  
404.33 whichever is later. The county agency must inform an applicant ~~that when the applicant~~

405.1 ~~submits the application by telephone or through Internet telepresence, the county agency~~  
405.2 ~~must receive a signed written application within 30 days of the date that the applicant~~  
405.3 ~~submitted the application by telephone or through Internet telepresence~~ of the application  
405.4 submission requirements in section 256P.04, subdivision 1a. The county agency must inform  
405.5 the applicant that any delay in submitting the application will reduce the benefits paid for  
405.6 the month of application. The county agency must inform a person that an application may  
405.7 be submitted before the person has an interview appointment. Upon receipt of a signed  
405.8 application, the county agency must stamp the date of receipt on the face of the application.  
405.9 The applicant may withdraw the application at any time prior to approval by giving written  
405.10 or oral notice to the county agency. The county agency must follow the notice requirements  
405.11 in section 256J.09, subdivision 3, when issuing a notice confirming the withdrawal.

405.12 Sec. 24. Minnesota Statutes 2022, section 256P.01, is amended by adding a subdivision  
405.13 to read:

405.14 Subd. 2b. **Date of application.** "Date of application" means the date on which the agency  
405.15 receives an applicant's application as a signed written application, an application submitted  
405.16 by telephone, or an application submitted through Internet telepresence. The child care  
405.17 assistance program under chapter 119B is exempt from this definition.

405.18 Sec. 25. Minnesota Statutes 2022, section 256P.04, is amended by adding a subdivision  
405.19 to read:

405.20 Subd. 1a. **Application submission.** An agency must offer, in person or by mail, the  
405.21 application forms prescribed by the commissioner as soon as a person makes a written or  
405.22 oral inquiry about assistance. Applications must be received by the agency as a signed  
405.23 written application, an application submitted by telephone, or an application submitted  
405.24 through Internet telepresence. When a person submits an application by telephone or through  
405.25 Internet telepresence, the agency must receive a signed written application within 30 days  
405.26 of the date that the person submitted the application by telephone or through Internet  
405.27 telepresence.

405.28 Sec. 26. **REVISOR INSTRUCTION.**

405.29 The revisor of statutes shall renumber the subdivisions in Minnesota Statutes, sections  
405.30 256D.02 and 256I.03, in alphabetical order, excluding the first subdivision in each section,  
405.31 and correct any cross-reference changes that result.

406.1 Sec. 27. **REPEALER.**

406.2 Minnesota Statutes 2022, section 256I.03, subdivision 6, is repealed.

406.3 **ARTICLE 9**

406.4 **DEPARTMENT OF HUMAN SERVICES OPERATIONS POLICY**

406.5 Section 1. Minnesota Statutes 2022, section 13.46, subdivision 4, is amended to read:

406.6 Subd. 4. **Licensing data.** (a) As used in this subdivision:

406.7 (1) "licensing data" are all data collected, maintained, used, or disseminated by the  
406.8 welfare system pertaining to persons licensed or registered or who apply for licensure or  
406.9 registration or who formerly were licensed or registered under the authority of the  
406.10 commissioner of human services. "Licensing data" includes data pertaining to persons or  
406.11 government entities certified under chapter 245H or section 245I.20. "License holder"  
406.12 includes "certification holder" under section 245H.01, subdivision 4, and a person or  
406.13 government entity issued a certification under section 245I.20;

406.14 (2) "client" means a person who is receiving services from a licensee or from an applicant  
406.15 for licensure; and

406.16 (3) "personal and personal financial data" are Social Security numbers, identity of and  
406.17 letters of reference, insurance information, reports from the Bureau of Criminal  
406.18 Apprehension, health examination reports, and social/home studies.

406.19 (b)(1)(i) Except as provided in paragraph (c), the following data on applicants, license  
406.20 holders, and former licensees are public: name, address, telephone number of licensees, the  
406.21 public email address provided by nonfamily foster care license holder, date of receipt of a  
406.22 completed application, dates of licensure, licensed capacity, type of client preferred, variances  
406.23 granted, record of training and education in child care and child development, type of  
406.24 dwelling, name and relationship of other family members, previous license history, class  
406.25 of license, the existence and status of complaints, and the number of serious injuries to or  
406.26 deaths of individuals in the licensed program as reported to the commissioner of human  
406.27 services, the local social services agency, or any other county welfare agency. For purposes  
406.28 of this clause, a serious injury is one that is treated by a physician.

406.29 (ii) Except as provided in item (v), when a correction order, an order to forfeit a fine,  
406.30 an order of license suspension, an order of temporary immediate suspension, an order of  
406.31 license revocation, an order of license denial, or an order of conditional license has been  
406.32 issued, or a complaint is resolved, the following data on current and former licensees and

407.1 applicants are public: the general nature of the complaint or allegations leading to the  
407.2 temporary immediate suspension; the substance and investigative findings of the licensing  
407.3 or maltreatment complaint, licensing violation, or substantiated maltreatment; the existence  
407.4 of settlement negotiations; the record of informal resolution of a licensing violation; orders  
407.5 of hearing; findings of fact; conclusions of law; specifications of the final correction order,  
407.6 fine, suspension, temporary immediate suspension, revocation, denial, or conditional license  
407.7 contained in the record of licensing action; whether a fine has been paid; and the status of  
407.8 any appeal of these actions.

407.9 (iii) When a license denial under section 245A.05 or a sanction under section 245A.07  
407.10 is based on a determination that a license holder, applicant, or controlling individual is  
407.11 responsible for maltreatment under section 626.557 or chapter 260E, the identity of the  
407.12 applicant, license holder, or controlling individual as the individual responsible for  
407.13 maltreatment is public data at the time of the issuance of the license denial or sanction.

407.14 (iv) When a license denial under section 245A.05 or a sanction under section 245A.07  
407.15 is based on a determination that a license holder, applicant, or controlling individual is  
407.16 disqualified under chapter 245C, the identity of the license holder, applicant, or controlling  
407.17 individual as the disqualified individual and the reason for the disqualification are public  
407.18 data at the time of the issuance of the licensing sanction or denial. If the applicant, license  
407.19 holder, or controlling individual requests reconsideration of the disqualification and the  
407.20 disqualification is affirmed, the reason for the disqualification and the reason to not set aside  
407.21 the disqualification are public data.

407.22 (v) A correction order or fine issued to a child care provider for a licensing violation is  
407.23 private data on individuals under section 13.02, subdivision 12, or nonpublic data under  
407.24 section 13.02, subdivision 9, if the correction order or fine is seven years old or older.

407.25 (2) For applicants who withdraw their application prior to licensure or denial of a license,  
407.26 the following data are public: the name of the applicant, the city and county in which the  
407.27 applicant was seeking licensure, the dates of the commissioner's receipt of the initial  
407.28 application and completed application, the type of license sought, and the date of withdrawal  
407.29 of the application.

407.30 (3) For applicants who are denied a license, the following data are public: the name and  
407.31 address of the applicant, the city and county in which the applicant was seeking licensure,  
407.32 the dates of the commissioner's receipt of the initial application and completed application,  
407.33 the type of license sought, the date of denial of the application, the nature of the basis for  
407.34 the denial, the existence of settlement negotiations, the record of informal resolution of a

408.1 denial, orders of hearings, findings of fact, conclusions of law, specifications of the final  
408.2 order of denial, and the status of any appeal of the denial.

408.3 (4) When maltreatment is substantiated under section 626.557 or chapter 260E and the  
408.4 victim and the substantiated perpetrator are affiliated with a program licensed under chapter  
408.5 245A, the commissioner of human services, local social services agency, or county welfare  
408.6 agency may inform the license holder where the maltreatment occurred of the identity of  
408.7 the substantiated perpetrator and the victim.

408.8 (5) Notwithstanding clause (1), for child foster care, only the name of the license holder  
408.9 and the status of the license are public if the county attorney has requested that data otherwise  
408.10 classified as public data under clause (1) be considered private data based on the best interests  
408.11 of a child in placement in a licensed program.

408.12 (c) The following are private data on individuals under section 13.02, subdivision 12,  
408.13 or nonpublic data under section 13.02, subdivision 9: personal and personal financial data  
408.14 on family day care program and family foster care program applicants and licensees and  
408.15 their family members who provide services under the license.

408.16 (d) The following are private data on individuals: the identity of persons who have made  
408.17 reports concerning licensees or applicants that appear in inactive investigative data, and the  
408.18 records of clients or employees of the licensee or applicant for licensure whose records are  
408.19 received by the licensing agency for purposes of review or in anticipation of a contested  
408.20 matter. The names of reporters of complaints or alleged violations of licensing standards  
408.21 under chapters 245A, 245B, 245C, and 245D, and applicable rules and alleged maltreatment  
408.22 under section 626.557 and chapter 260E, are confidential data and may be disclosed only  
408.23 as provided in section 260E.21, subdivision 4; 260E.35; or 626.557, subdivision 12b.

408.24 (e) Data classified as private, confidential, nonpublic, or protected nonpublic under this  
408.25 subdivision become public data if submitted to a court or administrative law judge as part  
408.26 of a disciplinary proceeding in which there is a public hearing concerning a license which  
408.27 has been suspended, immediately suspended, revoked, or denied.

408.28 (f) Data generated in the course of licensing investigations that relate to an alleged  
408.29 violation of law are investigative data under subdivision 3.

408.30 (g) Data that are not public data collected, maintained, used, or disseminated under this  
408.31 subdivision that relate to or are derived from a report as defined in section 260E.03, or  
408.32 626.5572, subdivision 18, are subject to the destruction provisions of sections 260E.35,  
408.33 subdivision 6, and 626.557, subdivision 12b.

409.1 (h) Upon request, not public data collected, maintained, used, or disseminated under  
409.2 this subdivision that relate to or are derived from a report of substantiated maltreatment as  
409.3 defined in section 626.557 or chapter 260E may be exchanged with the Department of  
409.4 Health for purposes of completing background studies pursuant to section 144.057 and with  
409.5 the Department of Corrections for purposes of completing background studies pursuant to  
409.6 section 241.021.

409.7 (i) Data on individuals collected according to licensing activities under chapters 245A  
409.8 and 245C, data on individuals collected by the commissioner of human services according  
409.9 to investigations under section 626.557 and chapters 245A, 245B, 245C, 245D, and 260E  
409.10 may be shared with the Department of Human Rights, the Department of Health, the  
409.11 Department of Corrections, the ombudsman for mental health and developmental disabilities,  
409.12 and the individual's professional regulatory board when there is reason to believe that laws  
409.13 or standards under the jurisdiction of those agencies may have been violated or the  
409.14 information may otherwise be relevant to the board's regulatory jurisdiction. Background  
409.15 study data on an individual who is the subject of a background study under chapter 245C  
409.16 for a licensed service for which the commissioner of human services is the license holder  
409.17 may be shared with the commissioner and the commissioner's delegate by the licensing  
409.18 division. Unless otherwise specified in this chapter, the identity of a reporter of alleged  
409.19 maltreatment or licensing violations may not be disclosed.

409.20 (j) In addition to the notice of determinations required under sections 260E.24,  
409.21 subdivisions 5 and 7, and 260E.30, subdivision 6, paragraphs (b), (c), (d), (e), and (f), if the  
409.22 commissioner or the local social services agency has determined that an individual is a  
409.23 substantiated perpetrator of maltreatment of a child based on sexual abuse, as defined in  
409.24 section 260E.03, and the commissioner or local social services agency knows that the  
409.25 individual is a person responsible for a child's care in another facility, the commissioner or  
409.26 local social services agency shall notify the head of that facility of this determination. The  
409.27 notification must include an explanation of the individual's available appeal rights and the  
409.28 status of any appeal. If a notice is given under this paragraph, the government entity making  
409.29 the notification shall provide a copy of the notice to the individual who is the subject of the  
409.30 notice.

409.31 (k) All not public data collected, maintained, used, or disseminated under this subdivision  
409.32 and subdivision 3 may be exchanged between the Department of Human Services, Licensing  
409.33 Division, and the Department of Corrections for purposes of regulating services for which  
409.34 the Department of Human Services and the Department of Corrections have regulatory  
409.35 authority.

410.1 Sec. 2. Minnesota Statutes 2022, section 62V.05, subdivision 4a, is amended to read:

410.2 Subd. 4a. **Background study required.** (a) The board must initiate background studies  
410.3 under section 245C.031 of:

410.4 (1) each navigator;

410.5 (2) each in-person assister; and

410.6 (3) each certified application counselor.

410.7 (b) The board may initiate the background studies required by paragraph (a) using the  
410.8 online NETStudy 2.0 system operated by the commissioner of human services.

410.9 (c) The board shall not permit any individual to provide any service or function listed  
410.10 in paragraph (a) until ~~the board has received notification from the commissioner of human~~  
410.11 ~~services indicating that the individual:~~

410.12 (1) the board has evaluated any notification received from the commissioner of human  
410.13 services indicating the individual's potential disqualifications and has determined that the  
410.14 individual is not disqualified under chapter 245C; or

410.15 (2) the board has determined that the individual is disqualified, but has received granted  
410.16 a set aside from the board of that disqualification according to sections 245C.22 and 245C.23.

410.17 (d) The board or its delegate shall review a reconsideration request of an individual in  
410.18 paragraph (a), including granting a set aside, according to the procedures and criteria in  
410.19 chapter 245C. The board shall notify the individual and the Department of Human Services  
410.20 of the board's decision.

410.21 Sec. 3. Minnesota Statutes 2022, section 122A.18, subdivision 8, is amended to read:

410.22 Subd. 8. **Background studies.** (a) The Professional Educator Licensing and Standards  
410.23 Board and the Board of School Administrators must initiate criminal history background  
410.24 studies of all first-time applicants for educator and administrator licenses under their  
410.25 jurisdiction. Applicants must include with their licensure applications:

410.26 (1) an executed criminal history consent form, including fingerprints; and

410.27 (2) payment to conduct the background study. The Professional Educator Licensing and  
410.28 Standards Board must deposit payments received under this subdivision in an account in  
410.29 the special revenue fund. Amounts in the account are annually appropriated to the  
410.30 Professional Educator Licensing and Standards Board to pay for the costs of background  
410.31 studies on applicants for licensure.

411.1 (b) The background study for all first-time ~~teaching~~ applicants for educator licenses  
411.2 must include a review of information from the Bureau of Criminal Apprehension, including  
411.3 criminal history data as defined in section 13.87, and must also include a review of the  
411.4 national criminal records repository. The superintendent of the Bureau of Criminal  
411.5 Apprehension is authorized to exchange fingerprints with the Federal Bureau of Investigation  
411.6 for purposes of the criminal history check.

411.7 (c) The Professional Educator Licensing and Standards Board may initiate criminal  
411.8 history background studies through the commissioner of human services according to section  
411.9 245C.031 to obtain background study data required under this chapter.

411.10 Sec. 4. Minnesota Statutes 2022, section 245A.02, subdivision 5a, is amended to read:

411.11 Subd. 5a. **Controlling individual.** (a) "Controlling individual" means an owner of a  
411.12 program or service provider licensed under this chapter and the following individuals, if  
411.13 applicable:

411.14 (1) each officer of the organization, including the chief executive officer and chief  
411.15 financial officer;

411.16 (2) the individual designated as the authorized agent under section 245A.04, subdivision  
411.17 1, paragraph (b);

411.18 (3) the individual designated as the compliance officer under section 256B.04, subdivision  
411.19 21, paragraph (g);

411.20 (4) each managerial official whose responsibilities include the direction of the  
411.21 management or policies of a program; ~~and~~

411.22 (5) the individual designated as the primary provider of care for a special family child  
411.23 care program under section 245A.14, subdivision 4, paragraph (i); and

411.24 (6) the president and treasurer of the board of directors of a nonprofit corporation.

411.25 (b) Controlling individual does not include:

411.26 (1) a bank, savings bank, trust company, savings association, credit union, industrial  
411.27 loan and thrift company, investment banking firm, or insurance company unless the entity  
411.28 operates a program directly or through a subsidiary;

411.29 (2) an individual who is a state or federal official, or state or federal employee, or a  
411.30 member or employee of the governing body of a political subdivision of the state or federal  
411.31 government that operates one or more programs, unless the individual is also an officer,

412.1 owner, or managerial official of the program, receives remuneration from the program, or  
412.2 owns any of the beneficial interests not excluded in this subdivision;

412.3 (3) an individual who owns less than five percent of the outstanding common shares of  
412.4 a corporation:

412.5 (i) whose securities are exempt under section 80A.45, clause (6); or

412.6 (ii) whose transactions are exempt under section 80A.46, clause (2);

412.7 (4) an individual who is a member of an organization exempt from taxation under section  
412.8 290.05, unless the individual is also an officer, owner, or managerial official of the program  
412.9 or owns any of the beneficial interests not excluded in this subdivision. This clause does  
412.10 not exclude from the definition of controlling individual an organization that is exempt from  
412.11 taxation; or

412.12 (5) an employee stock ownership plan trust, or a participant or board member of an  
412.13 employee stock ownership plan, unless the participant or board member is a controlling  
412.14 individual according to paragraph (a).

412.15 (c) For purposes of this subdivision, "managerial official" means an individual who has  
412.16 the decision-making authority related to the operation of the program, and the responsibility  
412.17 for the ongoing management of or direction of the policies, services, or employees of the  
412.18 program. A site director who has no ownership interest in the program is not considered to  
412.19 be a managerial official for purposes of this definition.

412.20 Sec. 5. Minnesota Statutes 2022, section 245A.02, subdivision 10b, is amended to read:

412.21 Subd. 10b. **Owner.** "Owner" means an individual or organization that has a direct or  
412.22 indirect ownership interest of five percent or more in a program licensed under this chapter.  
412.23 For purposes of this subdivision, "direct ownership interest" means the possession of equity  
412.24 in capital, stock, or profits of an organization, and "indirect ownership interest" means a  
412.25 direct ownership interest in an entity that has a direct or indirect ownership interest in a  
412.26 licensed program. For purposes of this chapter, "owner of a ~~nonprofit corporation~~" means  
412.27 ~~the president and treasurer of the board of directors or, for an entity owned by an employee~~  
412.28 ~~stock ownership plan,~~ means the president and treasurer of the entity. A government entity  
412.29 or nonprofit corporation that is issued a license under this chapter shall be designated the  
412.30 owner.

413.1 Sec. 6. Minnesota Statutes 2022, section 245A.04, subdivision 1, is amended to read:

413.2 Subdivision 1. **Application for licensure.** (a) An individual, organization, or government  
413.3 entity that is subject to licensure under section 245A.03 must apply for a license. The  
413.4 application must be made on the forms and in the manner prescribed by the commissioner.  
413.5 The commissioner shall provide the applicant with instruction in completing the application  
413.6 and provide information about the rules and requirements of other state agencies that affect  
413.7 the applicant. An applicant seeking licensure in Minnesota with headquarters outside of  
413.8 Minnesota must have a program office located within 30 miles of the Minnesota border.  
413.9 An applicant who intends to buy or otherwise acquire a program or services licensed under  
413.10 this chapter that is owned by another license holder must apply for a license under this  
413.11 chapter and comply with the application procedures in this section and section ~~245A.03~~  
413.12 245A.043.

413.13 The commissioner shall act on the application within 90 working days after a complete  
413.14 application and any required reports have been received from other state agencies or  
413.15 departments, counties, municipalities, or other political subdivisions. The commissioner  
413.16 shall not consider an application to be complete until the commissioner receives all of the  
413.17 required information.

413.18 When the commissioner receives an application for initial licensure that is incomplete  
413.19 because the applicant failed to submit required documents or that is substantially deficient  
413.20 because the documents submitted do not meet licensing requirements, the commissioner  
413.21 shall provide the applicant written notice that the application is incomplete or substantially  
413.22 deficient. In the written notice to the applicant the commissioner shall identify documents  
413.23 that are missing or deficient and give the applicant 45 days to resubmit a second application  
413.24 that is substantially complete. An applicant's failure to submit a substantially complete  
413.25 application after receiving notice from the commissioner is a basis for license denial under  
413.26 section 245A.05.

413.27 (b) An application for licensure must identify all controlling individuals as defined in  
413.28 section 245A.02, subdivision 5a, and must designate one individual to be the authorized  
413.29 agent. The application must be signed by the authorized agent and must include the authorized  
413.30 agent's first, middle, and last name; mailing address; and email address. By submitting an  
413.31 application for licensure, the authorized agent consents to electronic communication with  
413.32 the commissioner throughout the application process. The authorized agent must be  
413.33 authorized to accept service on behalf of all of the controlling individuals. A government  
413.34 entity that holds multiple licenses under this chapter may designate one authorized agent  
413.35 for all licenses issued under this chapter or may designate a different authorized agent for

414.1 each license. Service on the authorized agent is service on all of the controlling individuals.  
414.2 It is not a defense to any action arising under this chapter that service was not made on each  
414.3 controlling individual. The designation of a controlling individual as the authorized agent  
414.4 under this paragraph does not affect the legal responsibility of any other controlling individual  
414.5 under this chapter.

414.6 (c) An applicant or license holder must have a policy that prohibits license holders,  
414.7 employees, subcontractors, and volunteers, when directly responsible for persons served  
414.8 by the program, from abusing prescription medication or being in any manner under the  
414.9 influence of a chemical that impairs the individual's ability to provide services or care. The  
414.10 license holder must train employees, subcontractors, and volunteers about the program's  
414.11 drug and alcohol policy.

414.12 (d) An applicant and license holder must have a program grievance procedure that permits  
414.13 persons served by the program and their authorized representatives to bring a grievance to  
414.14 the highest level of authority in the program.

414.15 (e) The commissioner may limit communication during the application process to the  
414.16 authorized agent or the controlling individuals identified on the license application and for  
414.17 whom a background study was initiated under chapter 245C. The commissioner may require  
414.18 the applicant, except for child foster care, to demonstrate competence in the applicable  
414.19 licensing requirements by successfully completing a written examination. The commissioner  
414.20 may develop a prescribed written examination format.

414.21 (f) When an applicant is an individual, the applicant must provide:

414.22 (1) the applicant's taxpayer identification numbers including the Social Security number  
414.23 or Minnesota tax identification number, and federal employer identification number if the  
414.24 applicant has employees;

414.25 (2) at the request of the commissioner, a copy of the most recent filing with the secretary  
414.26 of state that includes the complete business name, if any;

414.27 (3) if doing business under a different name, the doing business as (DBA) name, as  
414.28 registered with the secretary of state;

414.29 (4) if applicable, the applicant's National Provider Identifier (NPI) number and Unique  
414.30 Minnesota Provider Identifier (UMPI) number; and

414.31 (5) at the request of the commissioner, the notarized signature of the applicant or  
414.32 authorized agent; and

415.1 (6) except for family foster care providers, an email address that will be made public  
415.2 subject to the requirements under section 13.46, subdivision 4, paragraph (b), clause (1),  
415.3 item (i).

415.4 (g) When an applicant is an organization, the applicant must provide:

415.5 (1) the applicant's taxpayer identification numbers including the Minnesota tax  
415.6 identification number and federal employer identification number;

415.7 (2) at the request of the commissioner, a copy of the most recent filing with the secretary  
415.8 of state that includes the complete business name, and if doing business under a different  
415.9 name, the doing business as (DBA) name, as registered with the secretary of state;

415.10 (3) the first, middle, and last name, and address for all individuals who will be controlling  
415.11 individuals, including all officers, owners, and managerial officials as defined in section  
415.12 245A.02, subdivision 5a, and the date that the background study was initiated by the applicant  
415.13 for each controlling individual;

415.14 (4) if applicable, the applicant's NPI number and UMPI number;

415.15 (5) the documents that created the organization and that determine the organization's  
415.16 internal governance and the relations among the persons that own the organization, have  
415.17 an interest in the organization, or are members of the organization, in each case as provided  
415.18 or authorized by the organization's governing statute, which may include a partnership  
415.19 agreement, bylaws, articles of organization, organizational chart, and operating agreement,  
415.20 or comparable documents as provided in the organization's governing statute; ~~and~~

415.21 (6) the notarized signature of the applicant or authorized agent; and

415.22 (7) an email address that will be made public subject to the requirements under section  
415.23 13.46, subdivision 4, paragraph (b), clause (1), item (i).

415.24 (h) When the applicant is a government entity, the applicant must provide:

415.25 (1) the name of the government agency, political subdivision, or other unit of government  
415.26 seeking the license and the name of the program or services that will be licensed;

415.27 (2) the applicant's taxpayer identification numbers including the Minnesota tax  
415.28 identification number and federal employer identification number;

415.29 (3) a letter signed by the manager, administrator, or other executive of the government  
415.30 entity authorizing the submission of the license application; and

415.31 (4) if applicable, the applicant's NPI number and UMPI number; and

416.1 (5) an email address that will be made public subject to the requirements under section  
416.2 13.46, subdivision 4, paragraph (b), clause (1), item (i).

416.3 (i) At the time of application for licensure or renewal of a license under this chapter, the  
416.4 applicant or license holder must acknowledge on the form provided by the commissioner  
416.5 if the applicant or license holder elects to receive any public funding reimbursement from  
416.6 the commissioner for services provided under the license that:

416.7 (1) the applicant's or license holder's compliance with the provider enrollment agreement  
416.8 or registration requirements for receipt of public funding may be monitored by the  
416.9 commissioner as part of a licensing investigation or licensing inspection; and

416.10 (2) noncompliance with the provider enrollment agreement or registration requirements  
416.11 for receipt of public funding that is identified through a licensing investigation or licensing  
416.12 inspection, or noncompliance with a licensing requirement that is a basis of enrollment for  
416.13 reimbursement for a service, may result in:

416.14 (i) a correction order or a conditional license under section 245A.06, or sanctions under  
416.15 section 245A.07;

416.16 (ii) nonpayment of claims submitted by the license holder for public program  
416.17 reimbursement;

416.18 (iii) recovery of payments made for the service;

416.19 (iv) disenrollment in the public payment program; or

416.20 (v) other administrative, civil, or criminal penalties as provided by law.

416.21 **EFFECTIVE DATE.** This section is effective the day following final enactment.

416.22 Sec. 7. Minnesota Statutes 2022, section 245A.04, subdivision 7, is amended to read:

416.23 **Subd. 7. Grant of license; license extension.** (a) If the commissioner determines that  
416.24 the program complies with all applicable rules and laws, the commissioner shall issue a  
416.25 license consistent with this section or, if applicable, a temporary change of ownership license  
416.26 under section 245A.043. At minimum, the license shall state:

416.27 (1) the name of the license holder;

416.28 (2) the address of the program;

416.29 (3) the effective date and expiration date of the license;

416.30 (4) the type of license;

- 417.1 (5) the maximum number and ages of persons that may receive services from the program;  
417.2 ~~and~~
- 417.3 (6) any special conditions of licensure; and  
417.4 (7) the public email address of the program.
- 417.5 (b) The commissioner may issue a license for a period not to exceed two years if:
- 417.6 (1) the commissioner is unable to conduct the ~~evaluation~~ or observation required by  
417.7 subdivision 4, paragraph (a), clause ~~(4)~~ (3), because the program is not yet operational;
- 417.8 (2) certain records and documents are not available because persons are not yet receiving  
417.9 services from the program; and
- 417.10 (3) the applicant complies with applicable laws and rules in all other respects.
- 417.11 (c) A decision by the commissioner to issue a license does not guarantee that any person  
417.12 or persons will be placed or cared for in the licensed program.
- 417.13 (d) Except as provided in paragraphs (f) and (g), the commissioner shall not issue or  
417.14 reissue a license if the applicant, license holder, or controlling individual has:
- 417.15 (1) been disqualified and the disqualification was not set aside and no variance has been  
417.16 granted;
- 417.17 (2) been denied a license under this chapter, within the past two years;
- 417.18 (3) had a license issued under this chapter revoked within the past five years;
- 417.19 (4) an outstanding debt related to a license fee, licensing fine, or settlement agreement  
417.20 for which payment is delinquent; or
- 417.21 (5) failed to submit the information required of an applicant under subdivision 1,  
417.22 paragraph (f) ~~or~~ (g), or (h), after being requested by the commissioner.
- 417.23 When a license issued under this chapter is revoked under clause (1) or (3), the license  
417.24 holder and controlling individual may not hold any license under chapter 245A for five  
417.25 years following the revocation, and other licenses held by the applicant, license holder, or  
417.26 controlling individual shall also be revoked.
- 417.27 (e) The commissioner shall not issue or reissue a license under this chapter if an individual  
417.28 living in the household where the services will be provided as specified under section  
417.29 245C.03, subdivision 1, has been disqualified and the disqualification has not been set aside  
417.30 and no variance has been granted.

418.1 (f) Pursuant to section 245A.07, subdivision 1, paragraph (b), when a license issued  
418.2 under this chapter has been suspended or revoked and the suspension or revocation is under  
418.3 appeal, the program may continue to operate pending a final order from the commissioner.  
418.4 If the license under suspension or revocation will expire before a final order is issued, a  
418.5 temporary provisional license may be issued provided any applicable license fee is paid  
418.6 before the temporary provisional license is issued.

418.7 (g) Notwithstanding paragraph (f), when a revocation is based on the disqualification  
418.8 of a controlling individual or license holder, and the controlling individual or license holder  
418.9 is ordered under section 245C.17 to be immediately removed from direct contact with  
418.10 persons receiving services or is ordered to be under continuous, direct supervision when  
418.11 providing direct contact services, the program may continue to operate only if the program  
418.12 complies with the order and submits documentation demonstrating compliance with the  
418.13 order. If the disqualified individual fails to submit a timely request for reconsideration, or  
418.14 if the disqualification is not set aside and no variance is granted, the order to immediately  
418.15 remove the individual from direct contact or to be under continuous, direct supervision  
418.16 remains in effect pending the outcome of a hearing and final order from the commissioner.

418.17 (h) For purposes of reimbursement for meals only, under the Child and Adult Care Food  
418.18 Program, Code of Federal Regulations, title 7, subtitle B, chapter II, subchapter A, part 226,  
418.19 relocation within the same county by a licensed family day care provider, shall be considered  
418.20 an extension of the license for a period of no more than 30 calendar days or until the new  
418.21 license is issued, whichever occurs first, provided the county agency has determined the  
418.22 family day care provider meets licensure requirements at the new location.

418.23 (i) Unless otherwise specified by statute, all licenses issued under this chapter expire at  
418.24 12:01 a.m. on the day after the expiration date stated on the license. A license holder must  
418.25 apply for and be granted a new license to operate the program or the program must not be  
418.26 operated after the expiration date.

418.27 (j) The commissioner shall not issue or reissue a license under this chapter if it has been  
418.28 determined that a tribal licensing authority has established jurisdiction to license the program  
418.29 or service.

418.30 **EFFECTIVE DATE.** This section is effective the day following final enactment.

419.1 Sec. 8. Minnesota Statutes 2022, section 245A.041, is amended by adding a subdivision  
419.2 to read:

419.3 Subd. 6. **First date of direct contact; documentation requirements.** Except for family  
419.4 child care, family foster care for children, and family adult day services that the license  
419.5 holder provides in the license holder's residence, license holders must document the first  
419.6 date that a background study subject has direct contact, as defined in section 245C.02,  
419.7 subdivision 11, with a person served by the license holder's program. Unless this chapter  
419.8 otherwise requires, if the license holder does not maintain the documentation required by  
419.9 this subdivision in the license holder's personnel files, the license holder must provide the  
419.10 documentation to the commissioner upon the commissioner's request.

419.11 **EFFECTIVE DATE.** This section is effective January 1, 2024.

419.12 Sec. 9. Minnesota Statutes 2022, section 245A.07, subdivision 2a, is amended to read:

419.13 Subd. 2a. **Immediate suspension expedited hearing.** (a) Within five working days of  
419.14 receipt of the license holder's timely appeal, the commissioner shall request assignment of  
419.15 an administrative law judge. The request must include a proposed date, time, and place of  
419.16 a hearing. A hearing must be conducted by an administrative law judge within 30 calendar  
419.17 days of the request for assignment, unless an extension is requested by either party and  
419.18 granted by the administrative law judge for good cause. The commissioner shall issue a  
419.19 notice of hearing by certified mail or personal service at least ten working days before the  
419.20 hearing. The scope of the hearing shall be limited solely to the issue of whether the temporary  
419.21 immediate suspension should remain in effect pending the commissioner's final order under  
419.22 section 245A.08, regarding a licensing sanction issued under subdivision 3 following the  
419.23 immediate suspension. For suspensions under subdivision 2, paragraph (a), clause (1), the  
419.24 burden of proof in expedited hearings under this subdivision shall be limited to the  
419.25 commissioner's demonstration that reasonable cause exists to believe that the license holder's  
419.26 actions or failure to comply with applicable law or rule poses, or the actions of other  
419.27 individuals or conditions in the program poses an imminent risk of harm to the health, safety,  
419.28 or rights of persons served by the program. "Reasonable cause" means there exist specific  
419.29 articulable facts or circumstances which provide the commissioner with a reasonable  
419.30 suspicion that there is an imminent risk of harm to the health, safety, or rights of persons  
419.31 served by the program. When the commissioner has determined there is reasonable cause  
419.32 to order the temporary immediate suspension of a license based on a violation of safe sleep  
419.33 requirements, as defined in section 245A.1435, the commissioner is not required to  
419.34 demonstrate that an infant died or was injured as a result of the safe sleep violations. For

420.1 suspensions under subdivision 2, paragraph (a), clause (2), the burden of proof in expedited  
420.2 hearings under this subdivision shall be limited to the commissioner's demonstration by a  
420.3 preponderance of the evidence that, since the license was revoked, the license holder  
420.4 committed additional violations of law or rule which may adversely affect the health or  
420.5 safety of persons served by the program.

420.6 (b) The administrative law judge shall issue findings of fact, conclusions, and a  
420.7 recommendation within ten working days from the date of hearing. The parties shall have  
420.8 ten calendar days to submit exceptions to the administrative law judge's report. The record  
420.9 shall close at the end of the ten-day period for submission of exceptions. The commissioner's  
420.10 final order shall be issued within ten working days from the close of the record. When an  
420.11 appeal of a temporary immediate suspension is withdrawn or dismissed, the commissioner  
420.12 shall issue a final order affirming the temporary immediate suspension within ten calendar  
420.13 days of the commissioner's receipt of the withdrawal or dismissal. Within 90 calendar days  
420.14 after an immediate suspension has been issued and the license holder has not submitted a  
420.15 timely appeal under subdivision 2, paragraph (b), or within 90 calendar days after a final  
420.16 order affirming an immediate suspension, the commissioner shall ~~make a determination~~  
420.17 regarding determine:

420.18 (1) whether a final licensing sanction shall be issued under subdivision 3, paragraph (a),  
420.19 clauses (1) to (5). The license holder shall continue to be prohibited from operation of the  
420.20 program during this 90-day period; or

420.21 (2) whether the outcome of related, ongoing investigations or judicial proceedings are  
420.22 necessary to determine if a final licensing sanction under subdivision 3, paragraph (a),  
420.23 clauses (1) to (5), will be issued, and persons served by the program remain at an imminent  
420.24 risk of harm during the investigation period or proceedings. If so, the commissioner shall  
420.25 issue a suspension order under subdivision 3, paragraph (a), clause (6).

420.26 (c) When the final order under paragraph (b) affirms an immediate suspension or the  
420.27 license holder does not submit a timely appeal of the immediate suspension, and a final  
420.28 licensing sanction is issued under subdivision 3 and the license holder appeals that sanction,  
420.29 the license holder continues to be prohibited from operation of the program pending a final  
420.30 commissioner's order under section 245A.08, subdivision 5, regarding the final licensing  
420.31 sanction.

420.32 (d) The license holder shall continue to be prohibited from operation of the program  
420.33 while a suspension order issued under paragraph (b), clause (2), remains in effect.

421.1 ~~(d)~~ (e) For suspensions under subdivision 2, paragraph (a), clause (3), the burden of  
421.2 proof in expedited hearings under this subdivision shall be limited to the commissioner's  
421.3 demonstration by a preponderance of the evidence that a criminal complaint and warrant  
421.4 or summons was issued for the license holder that was not dismissed, and that the criminal  
421.5 charge is an offense that involves fraud or theft against a program administered by the  
421.6 commissioner.

421.7 Sec. 10. Minnesota Statutes 2022, section 245A.07, subdivision 3, is amended to read:

421.8 Subd. 3. **License suspension, revocation, or fine.** (a) The commissioner may suspend  
421.9 or revoke a license, or impose a fine if:

421.10 (1) a license holder fails to comply fully with applicable laws or rules including but not  
421.11 limited to the requirements of this chapter and chapter 245C;

421.12 (2) a license holder, a controlling individual, or an individual living in the household  
421.13 where the licensed services are provided or is otherwise subject to a background study has  
421.14 been disqualified and the disqualification was not set aside and no variance has been granted;

421.15 (3) a license holder knowingly withholds relevant information from or gives false or  
421.16 misleading information to the commissioner in connection with an application for a license,  
421.17 in connection with the background study status of an individual, during an investigation,  
421.18 or regarding compliance with applicable laws or rules;

421.19 (4) a license holder is excluded from any program administered by the commissioner  
421.20 under section 245.095; ~~or~~

421.21 (5) revocation is required under section 245A.04, subdivision 7, paragraph (d); or

421.22 (6) suspension is necessary under subdivision 2a, paragraph (b), clause (2).

421.23 A license holder who has had a license issued under this chapter suspended, revoked,  
421.24 or has been ordered to pay a fine must be given notice of the action by certified mail or  
421.25 personal service. If mailed, the notice must be mailed to the address shown on the application  
421.26 or the last known address of the license holder. The notice must state in plain language the  
421.27 reasons the license was suspended or revoked, or a fine was ordered.

421.28 (b) If the license was suspended or revoked, the notice must inform the license holder  
421.29 of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts  
421.30 1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking  
421.31 a license. The appeal of an order suspending or revoking a license must be made in writing  
421.32 by certified mail or personal service. If mailed, the appeal must be postmarked and sent to

422.1 the commissioner within ten calendar days after the license holder receives notice that the  
422.2 license has been suspended or revoked. If a request is made by personal service, it must be  
422.3 received by the commissioner within ten calendar days after the license holder received the  
422.4 order. Except as provided in subdivision 2a, paragraph (c), if a license holder submits a  
422.5 timely appeal of an order suspending or revoking a license, the license holder may continue  
422.6 to operate the program as provided in section 245A.04, subdivision 7, paragraphs (f) and  
422.7 (g), until the commissioner issues a final order on the suspension or revocation.

422.8 (c)(1) If the license holder was ordered to pay a fine, the notice must inform the license  
422.9 holder of the responsibility for payment of fines and the right to a contested case hearing  
422.10 under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The appeal of an  
422.11 order to pay a fine must be made in writing by certified mail or personal service. If mailed,  
422.12 the appeal must be postmarked and sent to the commissioner within ten calendar days after  
422.13 the license holder receives notice that the fine has been ordered. If a request is made by  
422.14 personal service, it must be received by the commissioner within ten calendar days after  
422.15 the license holder received the order.

422.16 (2) The license holder shall pay the fines assessed on or before the payment date specified.  
422.17 If the license holder fails to fully comply with the order, the commissioner may issue a  
422.18 second fine or suspend the license until the license holder complies. If the license holder  
422.19 receives state funds, the state, county, or municipal agencies or departments responsible for  
422.20 administering the funds shall withhold payments and recover any payments made while the  
422.21 license is suspended for failure to pay a fine. A timely appeal shall stay payment of the fine  
422.22 until the commissioner issues a final order.

422.23 (3) A license holder shall promptly notify the commissioner of human services, in writing,  
422.24 when a violation specified in the order to forfeit a fine is corrected. If upon reinspection the  
422.25 commissioner determines that a violation has not been corrected as indicated by the order  
422.26 to forfeit a fine, the commissioner may issue a second fine. The commissioner shall notify  
422.27 the license holder by certified mail or personal service that a second fine has been assessed.  
422.28 The license holder may appeal the second fine as provided under this subdivision.

422.29 (4) Fines shall be assessed as follows:

422.30 (i) the license holder shall forfeit \$1,000 for each determination of maltreatment of a  
422.31 child under chapter 260E or the maltreatment of a vulnerable adult under section 626.557  
422.32 for which the license holder is determined responsible for the maltreatment under section  
422.33 260E.30, subdivision 4, paragraphs (a) and (b), or 626.557, subdivision 9c, paragraph (c);

423.1 (ii) if the commissioner determines that a determination of maltreatment for which the  
423.2 license holder is responsible is the result of maltreatment that meets the definition of serious  
423.3 maltreatment as defined in section 245C.02, subdivision 18, the license holder shall forfeit  
423.4 \$5,000;

423.5 (iii) for a program that operates out of the license holder's home and a program licensed  
423.6 under Minnesota Rules, parts 9502.0300 to 9502.0445, the fine assessed against the license  
423.7 holder shall not exceed \$1,000 for each determination of maltreatment;

423.8 (iv) the license holder shall forfeit \$200 for each occurrence of a violation of law or rule  
423.9 governing matters of health, safety, or supervision, including but not limited to the provision  
423.10 of adequate staff-to-child or adult ratios, and failure to comply with background study  
423.11 requirements under chapter 245C; and

423.12 (v) the license holder shall forfeit \$100 for each occurrence of a violation of law or rule  
423.13 other than those subject to a \$5,000, \$1,000, or \$200 fine in items (i) to (iv).

423.14 For purposes of this section, "occurrence" means each violation identified in the  
423.15 commissioner's fine order. Fines assessed against a license holder that holds a license to  
423.16 provide home and community-based services, as identified in section 245D.03, subdivision  
423.17 1, and a community residential setting or day services facility license under chapter 245D  
423.18 where the services are provided, may be assessed against both licenses for the same  
423.19 occurrence, but the combined amount of the fines shall not exceed the amount specified in  
423.20 this clause for that occurrence.

423.21 (5) When a fine has been assessed, the license holder may not avoid payment by closing,  
423.22 selling, or otherwise transferring the licensed program to a third party. In such an event, the  
423.23 license holder will be personally liable for payment. In the case of a corporation, each  
423.24 controlling individual is personally and jointly liable for payment.

423.25 (d) Except for background study violations involving the failure to comply with an order  
423.26 to immediately remove an individual or an order to provide continuous, direct supervision,  
423.27 the commissioner shall not issue a fine under paragraph (c) relating to a background study  
423.28 violation to a license holder who self-corrects a background study violation before the  
423.29 commissioner discovers the violation. A license holder who has previously exercised the  
423.30 provisions of this paragraph to avoid a fine for a background study violation may not avoid  
423.31 a fine for a subsequent background study violation unless at least 365 days have passed  
423.32 since the license holder self-corrected the earlier background study violation.

424.1 Sec. 11. Minnesota Statutes 2022, section 245A.10, subdivision 3, is amended to read:

424.2 Subd. 3. **Application fee for initial license or certification.** (a) For fees required under  
424.3 subdivision 1, an applicant for an initial license or certification issued by the commissioner  
424.4 shall submit a \$500 application fee with each new application required under this subdivision.  
424.5 An applicant for an initial day services facility license under chapter 245D shall submit a  
424.6 \$250 application fee with each new application. The application fee shall not be prorated,  
424.7 is nonrefundable, and is in lieu of the annual license or certification fee that expires on  
424.8 December 31. The commissioner shall not process an application until the application fee  
424.9 is paid.

424.10 (b) Except as provided in clauses (1) ~~to (3)~~ and (2), an applicant shall apply for a license  
424.11 to provide services at a specific location.

424.12 (1) For a license to provide home and community-based services to persons with  
424.13 disabilities or age 65 and older under chapter 245D, an applicant shall submit an application  
424.14 to provide services statewide. Notwithstanding paragraph (a), applications received by the  
424.15 commissioner between July 1, 2013, and December 31, 2013, for licensure of services  
424.16 provided under chapter 245D must include an application fee that is equal to the annual  
424.17 license renewal fee under subdivision 4, paragraph (b), or \$500, whichever is less.  
424.18 Applications received by the commissioner after January 1, 2014, must include the application  
424.19 fee required under paragraph (a). Applicants who meet the modified application criteria  
424.20 identified in section 245A.042, subdivision 2, are exempt from paying an application fee.

424.21 ~~(2) For a license to provide independent living assistance for youth under section 245A.22,~~  
424.22 ~~an applicant shall submit a single application to provide services statewide.~~

424.23 ~~(3)~~ (2) For a license for a private agency to provide foster care or adoption services under  
424.24 Minnesota Rules, parts 9545.0755 to 9545.0845, an applicant shall submit a single application  
424.25 to provide services statewide.

424.26 (c) The initial application fee charged under this subdivision does not include the  
424.27 temporary license surcharge under section 16E.22.

424.28 **EFFECTIVE DATE.** This section is effective the day following final enactment.

424.29 Sec. 12. Minnesota Statutes 2022, section 245A.10, subdivision 4, is amended to read:

424.30 Subd. 4. **License or certification fee for certain programs.** (a) Child care centers shall  
424.31 pay an annual nonrefundable license fee based on the following schedule:

		Child Care Center License Fee
425.1		
425.2	Licensed Capacity	
425.3	1 to 24 persons	\$200
425.4	25 to 49 persons	\$300
425.5	50 to 74 persons	\$400
425.6	75 to 99 persons	\$500
425.7	100 to 124 persons	\$600
425.8	125 to 149 persons	\$700
425.9	150 to 174 persons	\$800
425.10	175 to 199 persons	\$900
425.11	200 to 224 persons	\$1,000
425.12	225 or more persons	\$1,100

425.13 (b)(1) A program licensed to provide one or more of the home and community-based  
 425.14 services and supports identified under chapter 245D to persons with disabilities or age 65  
 425.15 and older, shall pay an annual nonrefundable license fee based on revenues derived from  
 425.16 the provision of services that would require licensure under chapter 245D during the calendar  
 425.17 year immediately preceding the year in which the license fee is paid, according to the  
 425.18 following schedule:

	License Holder Annual Revenue	License Fee
425.19		
425.20	less than or equal to \$10,000	\$200
425.21	greater than \$10,000 but less than or	
425.22	equal to \$25,000	\$300
425.23	greater than \$25,000 but less than or	
425.24	equal to \$50,000	\$400
425.25	greater than \$50,000 but less than or	
425.26	equal to \$100,000	\$500
425.27	greater than \$100,000 but less than or	
425.28	equal to \$150,000	\$600
425.29	greater than \$150,000 but less than or	
425.30	equal to \$200,000	\$800
425.31	greater than \$200,000 but less than or	
425.32	equal to \$250,000	\$1,000
425.33	greater than \$250,000 but less than or	
425.34	equal to \$300,000	\$1,200
425.35	greater than \$300,000 but less than or	
425.36	equal to \$350,000	\$1,400
425.37	greater than \$350,000 but less than or	
425.38	equal to \$400,000	\$1,600
425.39	greater than \$400,000 but less than or	
425.40	equal to \$450,000	\$1,800

426.1	greater than \$450,000 but less than or	
426.2	equal to \$500,000	\$2,000
426.3	greater than \$500,000 but less than or	
426.4	equal to \$600,000	\$2,250
426.5	greater than \$600,000 but less than or	
426.6	equal to \$700,000	\$2,500
426.7	greater than \$700,000 but less than or	
426.8	equal to \$800,000	\$2,750
426.9	greater than \$800,000 but less than or	
426.10	equal to \$900,000	\$3,000
426.11	greater than \$900,000 but less than or	
426.12	equal to \$1,000,000	\$3,250
426.13	greater than \$1,000,000 but less than or	
426.14	equal to \$1,250,000	\$3,500
426.15	greater than \$1,250,000 but less than or	
426.16	equal to \$1,500,000	\$3,750
426.17	greater than \$1,500,000 but less than or	
426.18	equal to \$1,750,000	\$4,000
426.19	greater than \$1,750,000 but less than or	
426.20	equal to \$2,000,000	\$4,250
426.21	greater than \$2,000,000 but less than or	
426.22	equal to \$2,500,000	\$4,500
426.23	greater than \$2,500,000 but less than or	
426.24	equal to \$3,000,000	\$4,750
426.25	greater than \$3,000,000 but less than or	
426.26	equal to \$3,500,000	\$5,000
426.27	greater than \$3,500,000 but less than or	
426.28	equal to \$4,000,000	\$5,500
426.29	greater than \$4,000,000 but less than or	
426.30	equal to \$4,500,000	\$6,000
426.31	greater than \$4,500,000 but less than or	
426.32	equal to \$5,000,000	\$6,500
426.33	greater than \$5,000,000 but less than or	
426.34	equal to \$7,500,000	\$7,000
426.35	greater than \$7,500,000 but less than or	
426.36	equal to \$10,000,000	\$8,500
426.37	greater than \$10,000,000 but less than or	
426.38	equal to \$12,500,000	\$10,000
426.39	greater than \$12,500,000 but less than or	
426.40	equal to \$15,000,000	\$14,000
426.41	greater than \$15,000,000	\$18,000

426.42 (2) If requested, the license holder shall provide the commissioner information to verify  
426.43 the license holder's annual revenues or other information as needed, including copies of  
426.44 documents submitted to the Department of Revenue.

427.1 (3) At each annual renewal, a license holder may elect to pay the highest renewal fee,  
427.2 and not provide annual revenue information to the commissioner.

427.3 (4) A license holder that knowingly provides the commissioner incorrect revenue amounts  
427.4 for the purpose of paying a lower license fee shall be subject to a civil penalty in the amount  
427.5 of double the fee the provider should have paid.

427.6 (5) Notwithstanding clause (1), a license holder providing services under one or more  
427.7 licenses under chapter 245B that are in effect on May 15, 2013, shall pay an annual license  
427.8 fee for calendar years 2014, 2015, and 2016, equal to the total license fees paid by the license  
427.9 holder for all licenses held under chapter 245B for calendar year 2013. For calendar year  
427.10 2017 and thereafter, the license holder shall pay an annual license fee according to clause  
427.11 (1).

427.12 (c) A substance use disorder treatment program licensed under chapter 245G, to provide  
427.13 substance use disorder treatment shall pay an annual nonrefundable license fee based on  
427.14 the following schedule:

427.15	Licensed Capacity	License Fee
427.16	1 to 24 persons	\$600
427.17	25 to 49 persons	\$800
427.18	50 to 74 persons	\$1,000
427.19	75 to 99 persons	\$1,200
427.20	100 or more persons	\$1,400

427.21 (d) A detoxification program licensed under Minnesota Rules, parts 9530.6510 to  
427.22 9530.6590, or a withdrawal management program licensed under chapter 245F shall pay  
427.23 an annual nonrefundable license fee based on the following schedule:

427.24	Licensed Capacity	License Fee
427.25	1 to 24 persons	\$760
427.26	25 to 49 persons	\$960
427.27	50 or more persons	\$1,160

427.28 A detoxification program that also operates a withdrawal management program at the same  
427.29 location shall only pay one fee based upon the licensed capacity of the program with the  
427.30 higher overall capacity.

427.31 (e) Except for child foster care, a residential facility licensed under Minnesota Rules,  
427.32 chapter 2960, to serve children shall pay an annual nonrefundable license fee based on the  
427.33 following schedule:

428.1	Licensed Capacity	License Fee
428.2	1 to 24 persons	\$1,000
428.3	25 to 49 persons	\$1,100
428.4	50 to 74 persons	\$1,200
428.5	75 to 99 persons	\$1,300
428.6	100 or more persons	\$1,400

428.7 (f) A residential facility licensed under section 245I.23 or Minnesota Rules, parts  
 428.8 9520.0500 to 9520.0670, to serve persons with mental illness shall pay an annual  
 428.9 nonrefundable license fee based on the following schedule:

428.10	Licensed Capacity	License Fee
428.11	1 to 24 persons	\$2,525
428.12	25 or more persons	\$2,725

428.13 (g) A residential facility licensed under Minnesota Rules, parts 9570.2000 to 9570.3400,  
 428.14 to serve persons with physical disabilities shall pay an annual nonrefundable license fee  
 428.15 based on the following schedule:

428.16	Licensed Capacity	License Fee
428.17	1 to 24 persons	\$450
428.18	25 to 49 persons	\$650
428.19	50 to 74 persons	\$850
428.20	75 to 99 persons	\$1,050
428.21	100 or more persons	\$1,250

428.22 ~~(h) A program licensed to provide independent living assistance for youth under section~~  
 428.23 ~~245A.22 shall pay an annual nonrefundable license fee of \$1,500.~~

428.24 ~~(h)~~ (h) A private agency licensed to provide foster care and adoption services under  
 428.25 Minnesota Rules, parts 9545.0755 to 9545.0845, shall pay an annual nonrefundable license  
 428.26 fee of \$875.

428.27 ~~(i)~~ (i) A program licensed as an adult day care center licensed under Minnesota Rules,  
 428.28 parts 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on the  
 428.29 following schedule:

428.30	Licensed Capacity	License Fee
428.31	1 to 24 persons	\$500
428.32	25 to 49 persons	\$700
428.33	50 to 74 persons	\$900

429.1 75 to 99 persons \$1,100

429.2 100 or more persons \$1,300

429.3 ~~(k)~~ (j) A program licensed to provide treatment services to persons with sexual  
429.4 psychopathic personalities or sexually dangerous persons under Minnesota Rules, parts  
429.5 9515.3000 to 9515.3110, shall pay an annual nonrefundable license fee of \$20,000.

429.6 ~~(k)~~ (k) A mental health clinic certified under section 245I.20 shall pay an annual  
429.7 nonrefundable certification fee of \$1,550. If the mental health clinic provides services at a  
429.8 primary location with satellite facilities, the satellite facilities shall be certified with the  
429.9 primary location without an additional charge.

429.10 **EFFECTIVE DATE.** This section is effective the day following final enactment.

429.11 Sec. 13. Minnesota Statutes 2022, section 245A.16, subdivision 1, is amended to read:

429.12 Subdivision 1. **Delegation of authority to agencies.** (a) County agencies and private  
429.13 agencies that have been designated or licensed by the commissioner to perform licensing  
429.14 functions and activities under section 245A.04 ~~and background studies for family child care~~  
429.15 ~~under chapter 245C~~; to recommend denial of applicants under section 245A.05; to issue  
429.16 correction orders, to issue variances, and recommend a conditional license under section  
429.17 245A.06; or to recommend suspending or revoking a license or issuing a fine under section  
429.18 245A.07, shall comply with rules and directives of the commissioner governing those  
429.19 functions and with this section. The following variances are excluded from the delegation  
429.20 of variance authority and may be issued only by the commissioner:

429.21 (1) dual licensure of family child care and child foster care, dual licensure of child and  
429.22 adult foster care, and adult foster care and family child care;

429.23 (2) adult foster care maximum capacity;

429.24 (3) adult foster care minimum age requirement;

429.25 (4) child foster care maximum age requirement;

429.26 (5) variances regarding disqualified individuals ~~except that, before the implementation~~  
429.27 ~~of NETStudy 2.0, county agencies may issue variances under section 245C.30 regarding~~  
429.28 ~~disqualified individuals when the county is responsible for conducting a consolidated~~  
429.29 ~~reconsideration according to sections 245C.25 and 245C.27, subdivision 2, clauses (a) and~~  
429.30 ~~(b), of a county maltreatment determination and a disqualification based on serious or~~  
429.31 ~~recurring maltreatment;~~

430.1 (6) the required presence of a caregiver in the adult foster care residence during normal  
430.2 sleeping hours;

430.3 (7) variances to requirements relating to chemical use problems of a license holder or a  
430.4 household member of a license holder; and

430.5 (8) variances to section 245A.53 for a time-limited period. If the commissioner grants  
430.6 a variance under this clause, the license holder must provide notice of the variance to all  
430.7 parents and guardians of the children in care.

430.8 Except as provided in section 245A.14, subdivision 4, paragraph (e), a county agency must  
430.9 not grant a license holder a variance to exceed the maximum allowable family child care  
430.10 license capacity of 14 children.

430.11 (b) A county agency that has been designated by the commissioner to issue family child  
430.12 care variances must:

430.13 (1) publish the county agency's policies and criteria for issuing variances on the county's  
430.14 public website and update the policies as necessary; and

430.15 (2) annually distribute the county agency's policies and criteria for issuing variances to  
430.16 all family child care license holders in the county.

430.17 ~~(e) Before the implementation of NET Study 2.0, county agencies must report information~~  
430.18 ~~about disqualification reconsiderations under sections 245C.25 and 245C.27, subdivision~~  
430.19 ~~2, paragraphs (a) and (b), and variances granted under paragraph (a), clause (5), to the~~  
430.20 ~~commissioner at least monthly in a format prescribed by the commissioner.~~

430.21 ~~(d)~~ (c) For family child care programs, the commissioner shall require a county agency  
430.22 to conduct one unannounced licensing review at least annually.

430.23 ~~(e)~~ (d) For family adult day services programs, the commissioner may authorize licensing  
430.24 reviews every two years after a licensee has had at least one annual review.

430.25 ~~(f)~~ (e) A license issued under this section may be issued for up to two years.

430.26 ~~(g)~~ (f) During implementation of chapter 245D, the commissioner shall consider:

430.27 (1) the role of counties in quality assurance;

430.28 (2) the duties of county licensing staff; and

430.29 (3) the possible use of joint powers agreements, according to section 471.59, with counties  
430.30 through which some licensing duties under chapter 245D may be delegated by the  
430.31 commissioner to the counties.

431.1 Any consideration related to this paragraph must meet all of the requirements of the corrective  
431.2 action plan ordered by the federal Centers for Medicare and Medicaid Services.

431.3 ~~(h)~~ (g) Licensing authority specific to section 245D.06, subdivisions 5, 6, 7, and 8, or  
431.4 successor provisions; and section 245D.061 or successor provisions, for family child foster  
431.5 care programs providing out-of-home respite, as identified in section 245D.03, subdivision  
431.6 1, paragraph (b), clause (1), is excluded from the delegation of authority to county and  
431.7 private agencies.

431.8 ~~(i)~~ (h) A county agency shall report to the commissioner, in a manner prescribed by the  
431.9 commissioner, the following information for a licensed family child care program:

431.10 (1) the results of each licensing review completed, including the date of the review, and  
431.11 any licensing correction order issued;

431.12 (2) any death, serious injury, or determination of substantiated maltreatment; and

431.13 (3) any fires that require the service of a fire department within 48 hours of the fire. The  
431.14 information under this clause must also be reported to the state fire marshal within two  
431.15 business days of receiving notice from a licensed family child care provider.

431.16 **EFFECTIVE DATE.** This section is effective the day following final enactment.

431.17 Sec. 14. **[245A.211] PRONE RESTRAINT PROHIBITION.**

431.18 **Subdivision 1. Applicability.** This section applies to all programs licensed or certified  
431.19 under this chapter, chapters 245D, 245F, 245G, 245H, and sections 245I.20 and 245I.23.

431.20 The requirements in this section are in addition to any applicable requirements for the use  
431.21 of holds or restraints for each license or certification type.

431.22 **Subd. 2. Definitions.** (a) "Mechanical restraint" means a restraint device that limits the  
431.23 voluntary movement of a person or the person's limbs.

431.24 (b) "Prone restraint" means a restraint that places a person in a face-down position with  
431.25 the person's chest in contact with the floor or other surface.

431.26 (c) "Restraint" means a physical hold, physical restraint, manual restraint, restraint  
431.27 equipment, or mechanical restraint that holds a person immobile or limits the voluntary  
431.28 movement of a person or the person's limbs.

431.29 **Subd. 3. Prone restraint prohibition.** (a) A license or certification holder must not use  
431.30 a prone restraint on any person receiving services in a program, except in the instances  
431.31 allowed by paragraphs (b) to (d).

432.1 (b) If a person rolls into a prone position during the use of a restraint, the person must  
432.2 be restored to a nonprone position as quickly as possible.

432.3 (c) If the applicable licensing requirements allow a program to use mechanical restraints,  
432.4 a person may be briefly held in a prone restraint for the purpose of applying mechanical  
432.5 restraints if the person is restored to a nonprone position as quickly as possible.

432.6 (d) If the applicable licensing requirements allow a program to use seclusion, a person  
432.7 may be briefly held in a prone restraint to allow staff to safely exit a seclusion room.

432.8 Subd. 4. **Contraindicated physical restraints.** A license or certification holder must  
432.9 not implement a restraint on a person receiving services in a program in a way that is  
432.10 contraindicated for any of the person's known medical or psychological conditions. Prior  
432.11 to using restraints on a person, the license or certification holder must assess and document  
432.12 a determination of any medical or psychological conditions that restraints are contraindicated  
432.13 for and the type of restraints that will not be used on the person based on this determination.

432.14 Sec. 15. Minnesota Statutes 2022, section 245C.02, subdivision 6a, is amended to read:

432.15 Subd. 6a. **Child care background study subject.** (a) "Child care background study  
432.16 subject" means an individual who is affiliated with a licensed child care center, certified  
432.17 license-exempt child care center, licensed family child care program, or legal nonlicensed  
432.18 child care provider authorized under chapter 119B, and who is:

432.19 (1) employed by a child care provider for compensation;

432.20 (2) assisting in the care of a child for a child care provider;

432.21 (3) a person applying for licensure, certification, or enrollment;

432.22 (4) a controlling individual as defined in section 245A.02, subdivision 5a;

432.23 (5) an individual 13 years of age or older who lives in the household where the licensed  
432.24 program will be provided and who is not receiving licensed services from the program;

432.25 (6) an individual ten to 12 years of age who lives in the household where the licensed  
432.26 services will be provided when the commissioner has reasonable cause as defined in section  
432.27 245C.02, subdivision 15;

432.28 (7) an individual who, without providing direct contact services at a licensed program,  
432.29 certified program, or program authorized under chapter 119B, may have unsupervised access  
432.30 to a child receiving services from a program when the commissioner has reasonable cause  
432.31 as defined in section 245C.02, subdivision 15; or

433.1 (8) a volunteer, contractor providing services for hire in the program, prospective  
433.2 employee, or other individual who has unsupervised physical access to a child served by a  
433.3 program and who is not under supervision by an individual listed in clause (1) or (5),  
433.4 regardless of whether the individual provides program services.

433.5 (b) Notwithstanding paragraph (a), an individual who is providing services that are not  
433.6 part of the child care program is not required to have a background study if:

433.7 (1) the child receiving services is signed out of the child care program for the duration  
433.8 that the services are provided;

433.9 (2) the licensed child care center, certified license-exempt child care center, licensed  
433.10 family child care program, or legal nonlicensed child care provider authorized under chapter  
433.11 119B has obtained advanced written permission from the parent authorizing the child to  
433.12 receive the services, which is maintained in the child's record;

433.13 (3) the licensed child care center, certified license-exempt child care center, licensed  
433.14 family child care program, or legal nonlicensed child care provider authorized under chapter  
433.15 119B maintains documentation on site that identifies the individual service provider and  
433.16 the services being provided; and

433.17 (4) the licensed child care center, certified license-exempt child care center, licensed  
433.18 family child care program, or legal nonlicensed child care provider authorized under chapter  
433.19 119B ensures that the service provider does not have unsupervised access to a child not  
433.20 receiving the provider's services.

433.21 Sec. 16. Minnesota Statutes 2022, section 245C.02, subdivision 11c, is amended to read:

433.22 Subd. 11c. **Entity.** "Entity" means any program, organization, license holder, government  
433.23 agency, or agency initiating required to initiate a background study.

433.24 Sec. 17. Minnesota Statutes 2022, section 245C.02, is amended by adding a subdivision  
433.25 to read:

433.26 Subd. 11f. **Employee.** "Employee" means an individual who provides services or seeks  
433.27 to provide services for the entity with which they are required to be affiliated in NETStudy  
433.28 2.0 and who is subject to oversight by the entity, which includes but is not limited to  
433.29 continuous, direct supervision by the entity and being subject to immediate removal from  
433.30 providing direct care services by the entity when required.

434.1 Sec. 18. Minnesota Statutes 2022, section 245C.02, is amended by adding a subdivision  
434.2 to read:

434.3 Subd. 22. **Volunteer.** "Volunteer" means an individual who provides or seeks to provide  
434.4 services for an entity without direct compensation for services provided, is required to be  
434.5 affiliated in NETStudy 2.0 and is subject to oversight by the entity, including but not limited  
434.6 to continuous, direct supervision and immediate removal from providing direct care services  
434.7 when required.

434.8 Sec. 19. Minnesota Statutes 2022, section 245C.03, subdivision 1, is amended to read:

434.9 Subdivision 1. **Licensed programs.** (a) The commissioner shall conduct a background  
434.10 study on:

434.11 (1) the person or persons applying for a license;

434.12 (2) an individual age 13 and over living in the household where the licensed program  
434.13 will be provided who is not receiving licensed services from the program;

434.14 (3) current or prospective employees ~~or contractors~~ of the applicant who will have direct  
434.15 contact with persons served by the facility, agency, or program;

434.16 (4) volunteers or student volunteers who will have direct contact with persons served  
434.17 by the program to provide program services if the contact is not under the continuous, direct  
434.18 supervision by an individual listed in clause (1) or (3);

434.19 (5) an individual age ten to 12 living in the household where the licensed services will  
434.20 be provided when the commissioner has reasonable cause as defined in section 245C.02,  
434.21 subdivision 15;

434.22 (6) an individual who, without providing direct contact services at a licensed program,  
434.23 may have unsupervised access to children or vulnerable adults receiving services from a  
434.24 program, when the commissioner has reasonable cause as defined in section 245C.02,  
434.25 subdivision 15;

434.26 (7) all controlling individuals as defined in section 245A.02, subdivision 5a;

434.27 (8) notwithstanding the other requirements in this subdivision, child care background  
434.28 study subjects as defined in section 245C.02, subdivision 6a; and

434.29 (9) notwithstanding clause (3), for children's residential facilities and foster residence  
434.30 settings, any adult working in the facility, whether or not the individual will have direct  
434.31 contact with persons served by the facility.

435.1 (b) For child foster care when the license holder resides in the home where foster care  
435.2 services are provided, a short-term substitute caregiver providing direct contact services for  
435.3 a child for less than 72 hours of continuous care is not required to receive a background  
435.4 study under this chapter.

435.5 (c) This subdivision applies to the following programs that must be licensed under  
435.6 chapter 245A:

435.7 (1) adult foster care;

435.8 (2) child foster care;

435.9 (3) children's residential facilities;

435.10 (4) family child care;

435.11 (5) licensed child care centers;

435.12 (6) licensed home and community-based services under chapter 245D;

435.13 (7) residential mental health programs for adults;

435.14 (8) substance use disorder treatment programs under chapter 245G;

435.15 (9) withdrawal management programs under chapter 245F;

435.16 (10) adult day care centers;

435.17 (11) family adult day services;

435.18 ~~(12) independent living assistance for youth;~~

435.19 ~~(13)~~ (12) detoxification programs;

435.20 ~~(14)~~ (13) community residential settings; and

435.21 ~~(15)~~ (14) intensive residential treatment services and residential crisis stabilization under  
435.22 chapter 245I.

435.23 **EFFECTIVE DATE.** This section is effective the day following final enactment.

435.24 Sec. 20. Minnesota Statutes 2022, section 245C.03, subdivision 1a, is amended to read:

435.25 Subd. 1a. **Procedure.** (a) Individuals and organizations that are required under this  
435.26 section to have or initiate background studies shall comply with the requirements of this  
435.27 chapter.

435.28 (b) All studies conducted under this section shall be conducted according to sections  
435.29 299C.60 to 299C.64, including the consent and self-disclosure required in section 299C.62,

436.1 subdivision 2. This requirement does not apply to subdivisions 1, paragraph (c), clauses (2)  
436.2 to (5), and 6a.

436.3 Sec. 21. Minnesota Statutes 2022, section 245C.03, subdivision 4, is amended to read:

436.4 Subd. 4. **Personnel pool agencies; temporary personnel agencies; educational**  
436.5 **programs; professional services agencies.** (a) The commissioner also may conduct studies  
436.6 on individuals specified in subdivision 1, paragraph (a), clauses (3) and (4), when the studies  
436.7 are initiated by:

436.8 (1) personnel pool agencies;

436.9 (2) temporary personnel agencies;

436.10 (3) educational programs that train individuals by providing direct contact services in  
436.11 licensed programs; and

436.12 (4) professional services agencies that are not licensed and ~~which contract~~ that work  
436.13 with licensed programs to provide direct contact services or individuals who provide direct  
436.14 contact services.

436.15 (b) Personnel pool agencies, temporary personnel agencies, and professional services  
436.16 agencies must employ the individuals providing direct care services for children, people  
436.17 with disabilities, or the elderly. Individuals must be affiliated in NETStudy 2.0 and subject  
436.18 to oversight by the entity, which includes but is not limited to continuous, direct supervision  
436.19 by the entity and being subject to immediate removal from providing direct care services  
436.20 by the entity when required.

436.21 Sec. 22. Minnesota Statutes 2022, section 245C.03, subdivision 5, is amended to read:

436.22 Subd. 5. **Other state agencies.** The commissioner shall conduct background studies on  
436.23 applicants and license holders under the jurisdiction of other state agencies who are required  
436.24 in other statutory sections to initiate background studies under this chapter, including the  
436.25 applicant's or license holder's employees, ~~contractors,~~ and volunteers when required under  
436.26 other statutory sections.

436.27 Sec. 23. Minnesota Statutes 2022, section 245C.03, subdivision 5a, is amended to read:

436.28 Subd. 5a. **Facilities serving children or adults licensed or regulated by the**  
436.29 **Department of Health.** (a) Except as specified in paragraph (b), the commissioner shall  
436.30 conduct background studies of:

437.1 (1) individuals providing services who have direct contact, as defined under section  
437.2 245C.02, subdivision 11, with patients and residents in hospitals, boarding care homes,  
437.3 outpatient surgical centers licensed under sections 144.50 to 144.58; nursing homes and  
437.4 home care agencies licensed under chapter 144A; assisted living facilities and assisted living  
437.5 facilities with dementia care licensed under chapter 144G; and board and lodging  
437.6 establishments that are registered to provide supportive or health supervision services under  
437.7 section 157.17;

437.8 (2) individuals specified in subdivision 2 who provide direct contact services in a nursing  
437.9 home or a home care agency licensed under chapter 144A; an assisted living facility or  
437.10 assisted living facility with dementia care licensed under chapter 144G; or a boarding care  
437.11 home licensed under sections 144.50 to 144.58. If the individual undergoing a study resides  
437.12 outside of Minnesota, the study must include a check for substantiated findings of  
437.13 maltreatment of adults and children in the individual's state of residence when the state  
437.14 makes the information available;

437.15 (3) all other employees in assisted living facilities or assisted living facilities with  
437.16 dementia care licensed under chapter 144G, nursing homes licensed under chapter 144A,  
437.17 and boarding care homes licensed under sections 144.50 to 144.58. A disqualification of  
437.18 an individual in this section shall disqualify the individual from positions allowing direct  
437.19 contact with or access to patients or residents receiving services. "Access" means physical  
437.20 access to a client or the client's personal property without continuous, direct supervision as  
437.21 defined in section 245C.02, subdivision 8, when the employee's employment responsibilities  
437.22 do not include providing direct contact services;

437.23 (4) individuals employed by a supplemental nursing services agency, as defined under  
437.24 section 144A.70, who are providing services in health care facilities;

437.25 (5) controlling persons of a supplemental nursing services agency, as defined by section  
437.26 144A.70; and

437.27 (6) license applicants, owners, managerial officials, and controlling individuals who are  
437.28 required under section 144A.476, subdivision 1, or 144G.13, subdivision 1, to undergo a  
437.29 background study under this chapter, regardless of the licensure status of the license applicant,  
437.30 owner, managerial official, or controlling individual.

437.31 (b) ~~The commissioner of human services shall not conduct~~ An entity shall not initiate a  
437.32 background study on any individual identified in paragraph (a), clauses (1) to (5), if the  
437.33 individual has a valid license issued by a health-related licensing board as defined in section  
437.34 214.01, subdivision 2, and has completed the criminal background check as required in

438.1 section 214.075. An entity that is affiliated with individuals who meet the requirements of  
438.2 this paragraph must separate those individuals from the entity's roster for NETStudy 2.0.  
438.3 The Department of Human Services is not liable for conducting background studies that  
438.4 have been submitted or not removed from the roster in violation of this provision.

438.5 (c) If a facility or program is licensed by the Department of Human Services and the  
438.6 Department of Health and is subject to the background study provisions of this chapter, the  
438.7 Department of Human Services is solely responsible for the background studies of individuals  
438.8 in the jointly licensed program.

438.9 (d) The commissioner of health shall review and make decisions regarding reconsideration  
438.10 requests, including whether to grant variances, according to the procedures and criteria in  
438.11 this chapter. The commissioner of health shall inform the requesting individual and the  
438.12 Department of Human Services of the commissioner of health's decision regarding the  
438.13 reconsideration. The commissioner of health's decision to grant or deny a reconsideration  
438.14 of a disqualification is a final administrative agency action.

438.15 Sec. 24. Minnesota Statutes 2022, section 245C.031, subdivision 1, is amended to read:

438.16 Subdivision 1. **Alternative background studies.** (a) The commissioner shall conduct  
438.17 an alternative background study of individuals listed in this section.

438.18 (b) Notwithstanding other sections of this chapter, all alternative background studies  
438.19 except subdivision 12 shall be conducted according to this section and with sections 299C.60  
438.20 to 299C.64, including the consent and self-disclosure required in section 299C.62, subdivision  
438.21 2.

438.22 (c) All terms in this section shall have the definitions provided in section 245C.02.

438.23 (d) The entity that submits an alternative background study request under this section  
438.24 shall submit the request to the commissioner according to section 245C.05.

438.25 (e) The commissioner shall comply with the destruction requirements in section 245C.051.

438.26 (f) Background studies conducted under this section are subject to the provisions of  
438.27 section 245C.32.

438.28 (g) The commissioner shall forward all information that the commissioner receives under  
438.29 section 245C.08 to the entity that submitted the alternative background study request under  
438.30 subdivision 2. The commissioner shall not make any eligibility determinations regarding  
438.31 background studies conducted under this section.

439.1 Sec. 25. Minnesota Statutes 2022, section 245C.031, subdivision 4, is amended to read:

439.2 Subd. 4. **Applicants, licensees, and other occupations regulated by the commissioner**  
439.3 **of health.** The commissioner shall conduct an alternative background study, including a  
439.4 check of state data, and a national criminal history records check of the following individuals.  
439.5 For studies under this section, the following persons shall complete a consent form and  
439.6 criminal history disclosure form:

439.7 (1) An applicant for initial licensure, temporary licensure, or relicensure after a lapse in  
439.8 licensure as an audiologist or speech-language pathologist or an applicant for initial  
439.9 certification as a hearing instrument dispenser who must submit to a background study  
439.10 under section 144.0572.

439.11 (2) An applicant for a renewal license or certificate as an audiologist, speech-language  
439.12 pathologist, or hearing instrument dispenser who was licensed or obtained a certificate  
439.13 before January 1, 2018.

439.14 Sec. 26. Minnesota Statutes 2022, section 245C.05, subdivision 1, is amended to read:

439.15 Subdivision 1. **Individual studied.** (a) The individual who is the subject of the  
439.16 background study must provide the applicant, license holder, or other entity under section  
439.17 245C.04 with sufficient information to ensure an accurate study, including:

439.18 (1) the individual's first, middle, and last name and all other names by which the  
439.19 individual has been known;

439.20 (2) current home address, city, and state of residence;

439.21 (3) current zip code;

439.22 (4) sex;

439.23 (5) date of birth;

439.24 (6) driver's license number or state identification number or, for those without a driver's  
439.25 license or state identification card, an acceptable form of identification as determined by  
439.26 the commissioner; and

439.27 (7) upon implementation of NETStudy 2.0, the home address, city, county, and state of  
439.28 residence for the past five years.

439.29 (b) Every subject of a background study conducted or initiated by counties or private  
439.30 agencies under this chapter must also provide the home address, city, county, and state of  
439.31 residence for the past five years.

440.1 (c) Every subject of a background study related to private agency adoptions or related  
440.2 to child foster care licensed through a private agency, who is 18 years of age or older, shall  
440.3 also provide the commissioner a signed consent for the release of any information received  
440.4 from national crime information databases to the private agency that initiated the background  
440.5 study.

440.6 (d) The subject of a background study who is 18 years of age or older shall provide  
440.7 fingerprints and a photograph as required in subdivision 5. The subject of a background  
440.8 study who is 17 years of age or younger shall provide fingerprints and a photograph only  
440.9 as required in subdivision 5a.

440.10 (e) The subject of a background study shall submit a completed criminal and maltreatment  
440.11 history records check consent form and criminal history disclosure form for applicable  
440.12 national and state level record checks.

440.13 Sec. 27. Minnesota Statutes 2022, section 245C.05, subdivision 5a, is amended to read:

440.14 Subd. 5a. **Background study requirements for minors.** (a) A background study  
440.15 completed under this chapter on a subject who is required to be studied under section  
440.16 245C.03, subdivision 1, and is 17 years of age or younger shall be completed by the  
440.17 commissioner for:

440.18 (1) a legal nonlicensed child care provider authorized under chapter 119B;

440.19 (2) a licensed family child care program; or

440.20 (3) a licensed foster care home.

440.21 (b) The subject shall submit to the commissioner only the information under subdivision  
440.22 1, paragraph (a).

440.23 (c) Notwithstanding paragraph (b), a subject who is 17 years of age or younger is required  
440.24 to submit fingerprints and a photograph, and the commissioner shall conduct a national  
440.25 criminal history record check must provide the commissioner with a set of the background  
440.26 study subject's classifiable fingerprints and photograph, if:

440.27 (1) the commissioner has reasonable cause to require a national criminal history record  
440.28 check defined in section 245C.02, subdivision 15a; or

440.29 (2) under paragraph (a), clauses (1) and (2), the subject is employed by the provider or  
440.30 supervises children served by the program.

441.1 ~~(d) A subject who is 17 years of age or younger is required to submit~~  
441.2 ~~non-fingerprint-based data according to section 245C.08, subdivision 1, paragraph (a),~~  
441.3 ~~clause (6), item (iii), and the commissioner shall conduct the check if:~~

441.4 ~~(1) the commissioner has reasonable cause to require a national criminal history record~~  
441.5 ~~check defined in section 245C.02, subdivision 15a; or~~

441.6 ~~(2) the subject is employed by the provider or supervises children served by the program~~  
441.7 ~~under paragraph (a), clauses (1) and (2).~~

441.8 Sec. 28. Minnesota Statutes 2022, section 245C.05, is amended by adding a subdivision  
441.9 to read:

441.10 Subd. 8. **Study submitted.** The entity with which the background study subject is seeking  
441.11 affiliation shall initiate the background study in the NETStudy 2.0 system.

441.12 Sec. 29. Minnesota Statutes 2022, section 245C.07, is amended to read:

441.13 **245C.07 STUDY SUBJECT AFFILIATED WITH MULTIPLE FACILITIES.**

441.14 (a) Subject to the conditions in paragraph (d), when a license holder, applicant, or other  
441.15 entity owns multiple programs or services that are licensed by the Department of Human  
441.16 Services, Department of Health, or Department of Corrections, only one background study  
441.17 is required for an individual who provides direct contact services in one or more of the  
441.18 licensed programs or services if:

441.19 (1) the license holder designates one individual with one address and telephone number  
441.20 as the person to receive sensitive background study information for the multiple licensed  
441.21 programs or services that depend on the same background study; and

441.22 (2) the individual designated to receive the sensitive background study information is  
441.23 capable of determining, upon request of the department, whether a background study subject  
441.24 is providing direct contact services in one or more of the license holder's programs or services  
441.25 and, if so, at which location or locations.

441.26 (b) When a license holder maintains background study compliance for multiple licensed  
441.27 programs according to paragraph (a), and one or more of the licensed programs closes, the  
441.28 license holder shall immediately notify the commissioner which staff must be transferred  
441.29 to an active license so that the background studies can be electronically paired with the  
441.30 license holder's active program.

442.1 (c) When a background study is being initiated by a licensed program or service or a  
442.2 foster care provider that is also licensed under chapter 144G, a study subject affiliated with  
442.3 multiple licensed programs or services may attach to the background study form a cover  
442.4 letter indicating the additional names of the programs or services, addresses, and background  
442.5 study identification numbers.

442.6 When the commissioner receives a notice, the commissioner shall notify each program  
442.7 or service identified by the background study subject of the study results.

442.8 The background study notice the commissioner sends to the subsequent agencies shall  
442.9 satisfy those programs' or services' responsibilities for initiating a background study on that  
442.10 individual.

442.11 (d) If a background study was conducted on an individual related to child foster care  
442.12 and the requirements under paragraph (a) are met, the background study is transferable  
442.13 across all licensed programs. If a background study was conducted on an individual under  
442.14 a license other than child foster care and the requirements under paragraph (a) are met, the  
442.15 background study is transferable to all licensed programs except child foster care.

442.16 (e) The provisions of this section that allow a single background study in one or more  
442.17 licensed programs or services do not apply to background studies submitted by adoption  
442.18 agencies, supplemental nursing services agencies, personnel pool agencies, educational  
442.19 programs, professional services agencies, temporary personnel agencies, and unlicensed  
442.20 personal care provider organizations.

442.21 (f) For an entity operating under NETStudy 2.0, the entity's active roster must be the  
442.22 system used to document when a background study subject is affiliated with multiple entities.  
442.23 For a background study to be transferable:

442.24 (1) the background study subject must be on and moving to a roster for which the person  
442.25 designated to receive sensitive background study information is the same; and

442.26 (2) the same entity must own or legally control both the roster from which the transfer  
442.27 is occurring and the roster to which the transfer is occurring. For an entity that holds or  
442.28 controls multiple licenses, or unlicensed personal care provider organizations, there must  
442.29 be a common highest level entity that has a legally identifiable structure that can be verified  
442.30 through records available from the secretary of state.

443.1 Sec. 30. Minnesota Statutes 2022, section 245C.08, subdivision 1, is amended to read:

443.2 Subdivision 1. **Background studies conducted by Department of Human Services.** (a)

443.3 For a background study conducted by the Department of Human Services, the commissioner  
443.4 shall review:

443.5 (1) information related to names of substantiated perpetrators of maltreatment of  
443.6 vulnerable adults that has been received by the commissioner as required under section  
443.7 626.557, subdivision 9c, paragraph (j);

443.8 (2) the commissioner's records relating to the maltreatment of minors in licensed  
443.9 programs, and from findings of maltreatment of minors as indicated through the social  
443.10 service information system;

443.11 (3) information from juvenile courts as required in subdivision 4 for individuals listed  
443.12 in section 245C.03, subdivision 1, paragraph (a), when there is reasonable cause;

443.13 (4) information from the Bureau of Criminal Apprehension, including information  
443.14 regarding a background study subject's registration in Minnesota as a predatory offender  
443.15 under section 243.166;

443.16 (5) except as provided in clause (6), information received as a result of submission of  
443.17 fingerprints for a national criminal history record check, as defined in section 245C.02,  
443.18 subdivision 13c, when the commissioner has reasonable cause for a national criminal history  
443.19 record check as defined under section 245C.02, subdivision 15a, or as required under section  
443.20 144.057, subdivision 1, clause (2);

443.21 (6) for a background study related to a child foster family setting application for licensure,  
443.22 foster residence settings, children's residential facilities, a transfer of permanent legal and  
443.23 physical custody of a child under sections 260C.503 to 260C.515, or adoptions, and for a  
443.24 background study required for family child care, certified license-exempt child care, child  
443.25 care centers, and legal nonlicensed child care authorized under chapter 119B, the  
443.26 commissioner shall also review:

443.27 (i) information from the child abuse and neglect registry for any state in which the  
443.28 background study subject has resided for the past five years;

443.29 (ii) when the background study subject is 18 years of age or older, or a minor under  
443.30 section 245C.05, subdivision 5a, paragraph (c), information received following submission  
443.31 of fingerprints for a national criminal history record check; and

443.32 (iii) when the background study subject is 18 years of age or older or a minor under  
443.33 section 245C.05, subdivision 5a, ~~paragraph (d)~~, for licensed family child care, certified

444.1 license-exempt child care, licensed child care centers, and legal nonlicensed child care  
444.2 authorized under chapter 119B, information obtained using non-fingerprint-based data  
444.3 including information from the criminal and sex offender registries for any state in which  
444.4 the background study subject resided for the past five years and information from the national  
444.5 crime information database and the national sex offender registry; and

444.6 (7) for a background study required for family child care, certified license-exempt child  
444.7 care centers, licensed child care centers, and legal nonlicensed child care authorized under  
444.8 chapter 119B, the background study shall also include, to the extent practicable, a name  
444.9 and date-of-birth search of the National Sex Offender Public website.

444.10 (b) Notwithstanding expungement by a court, the commissioner may consider information  
444.11 obtained under paragraph (a), clauses (3) and (4), unless the commissioner received notice  
444.12 of the petition for expungement and the court order for expungement is directed specifically  
444.13 to the commissioner.

444.14 (c) The commissioner shall also review criminal case information received according  
444.15 to section 245C.04, subdivision 4a, from the Minnesota court information system that relates  
444.16 to individuals who have already been studied under this chapter and who remain affiliated  
444.17 with the agency that initiated the background study.

444.18 (d) When the commissioner has reasonable cause to believe that the identity of a  
444.19 background study subject is uncertain, the commissioner may require the subject to provide  
444.20 a set of classifiable fingerprints for purposes of completing a fingerprint-based record check  
444.21 with the Bureau of Criminal Apprehension. Fingerprints collected under this paragraph  
444.22 shall not be saved by the commissioner after they have been used to verify the identity of  
444.23 the background study subject against the particular criminal record in question.

444.24 (e) The commissioner may inform the entity that initiated a background study under  
444.25 NETStudy 2.0 of the status of processing of the subject's fingerprints.

444.26 Sec. 31. Minnesota Statutes 2022, section 245C.10, subdivision 4, is amended to read:

444.27 Subd. 4. **Temporary personnel agencies, personnel pool agencies, educational**  
444.28 **programs, and professional services agencies.** The commissioner shall recover the cost  
444.29 of the background studies initiated by temporary personnel agencies, personnel pool agencies,  
444.30 educational programs, and professional services agencies that initiate background studies  
444.31 under section 245C.03, subdivision 4, through a fee of no more than \$42 per study charged  
444.32 to the agency. The fees collected under this subdivision are appropriated to the commissioner  
444.33 for the purpose of conducting background studies.

445.1 Sec. 32. Minnesota Statutes 2022, section 245C.30, subdivision 2, is amended to read:

445.2 Subd. 2. **Disclosure of reason for disqualification.** (a) The commissioner may not grant  
445.3 a variance for a disqualified individual unless the applicant, license-exempt child care center  
445.4 certification holder, or license holder requests the variance and the disqualified individual  
445.5 provides written consent for the commissioner to disclose to the applicant, license-exempt  
445.6 child care center certification holder, or license holder the reason for the disqualification.

445.7 (b) This subdivision does not apply to programs licensed to provide family child care  
445.8 for children, foster care for children in the provider's own home, or foster care or day care  
445.9 services for adults in the provider's own home. ~~When the commissioner grants a variance~~  
445.10 ~~for a disqualified individual in connection with a license to provide the services specified~~  
445.11 ~~in this paragraph, the disqualified individual's consent is not required to disclose the reason~~  
445.12 ~~for the disqualification to the license holder in the variance issued under subdivision 1,~~  
445.13 ~~provided that the commissioner may not disclose the reason for the disqualification if the~~  
445.14 ~~disqualification is based on a felony-level conviction for a drug-related offense within the~~  
445.15 ~~past five years.~~

445.16 Sec. 33. Minnesota Statutes 2022, section 245C.31, subdivision 1, is amended to read:

445.17 Subdivision 1. **Board determines disciplinary or corrective action.** ~~(a)~~ The  
445.18 commissioner shall notify a health-related licensing board as defined in section 214.01,  
445.19 subdivision 2, if the commissioner determines that an individual who is licensed by the  
445.20 health-related licensing board and who is included on the board's roster list provided in  
445.21 accordance with subdivision 3a is responsible for substantiated maltreatment under section  
445.22 626.557 or chapter 260E, in accordance with subdivision 2. Upon receiving notification,  
445.23 the health-related licensing board shall make a determination as to whether to impose  
445.24 disciplinary or corrective action under chapter 214.

445.25 ~~(b) This section does not apply to a background study of an individual regulated by a~~  
445.26 ~~health-related licensing board if the individual's study is related to child foster care, adult~~  
445.27 ~~foster care, or family child care licensure.~~

445.28 Sec. 34. Minnesota Statutes 2022, section 245C.33, subdivision 4, is amended to read:

445.29 Subd. 4. **Information commissioner reviews.** (a) The commissioner shall review the  
445.30 following information regarding the background study subject:

445.31 (1) the information under section 245C.08, subdivisions 1, 3, and 4;

446.1 (2) information from the child abuse and neglect registry for any state in which the  
446.2 subject has resided for the past five years; and

446.3 (3) information from national crime information databases, when required under section  
446.4 245C.08.

446.5 (b) The commissioner shall provide any information collected under this subdivision to  
446.6 the county or private agency that initiated the background study. The commissioner shall  
446.7 also provide the agency:

446.8 ~~(1) with a notice~~ whether the information collected shows that the subject of the  
446.9 background study has a conviction listed in United States Code, title 42, section  
446.10 671(a)(20)(A); ~~and~~

446.11 ~~(2) for background studies conducted under subdivision 1, paragraph (a), the date of all~~  
446.12 ~~adoption-related background studies completed on the subject by the commissioner after~~  
446.13 ~~June 30, 2007, and the name of the county or private agency that initiated the adoption-related~~  
446.14 ~~background study.~~

446.15 Sec. 35. Minnesota Statutes 2022, section 245H.13, subdivision 9, is amended to read:

446.16 Subd. 9. **Behavior guidance.** The certified center must ensure that staff and volunteers  
446.17 use positive behavior guidance and do not subject children to:

446.18 (1) corporal punishment, including but not limited to rough handling, shoving, hair  
446.19 pulling, ear pulling, shaking, slapping, kicking, biting, pinching, hitting, and spanking;

446.20 (2) humiliation;

446.21 (3) abusive language;

446.22 (4) the use of mechanical restraints, including tying;

446.23 (5) the use of physical restraints other than to physically hold a child when containment  
446.24 is necessary to protect a child or others from harm; ~~or~~

446.25 (6) prone restraints, as prohibited by section 245A.211; or

446.26 ~~(6)~~ (7) the withholding or forcing of food and other basic needs.

446.27 Sec. 36. Minnesota Statutes 2022, section 245I.20, subdivision 10, is amended to read:

446.28 Subd. 10. **Application procedures.** (a) The applicant for certification must submit any  
446.29 documents that the commissioner requires on forms approved by the commissioner.

447.1 (b) Upon submitting an application for certification, an applicant must pay the application  
447.2 fee required by section 245A.10, subdivision 3.

447.3 (c) The commissioner must act on an application within 90 working days of receiving  
447.4 a completed application.

447.5 (d) When the commissioner receives an application for initial certification that is  
447.6 incomplete because the applicant failed to submit required documents or is deficient because  
447.7 the submitted documents do not meet certification requirements, the commissioner must  
447.8 provide the applicant with written notice that the application is incomplete or deficient. In  
447.9 the notice, the commissioner must identify the particular documents that are missing or  
447.10 deficient and give the applicant 45 days to submit a second application that is complete. An  
447.11 applicant's failure to submit a complete application within 45 days after receiving notice  
447.12 from the commissioner is a basis for certification denial.

447.13 (e) The commissioner must give notice of a denial to an applicant when the commissioner  
447.14 has made the decision to deny the certification application. In the notice of denial, the  
447.15 commissioner must state the reasons for the denial in plain language. The commissioner  
447.16 must send or deliver the notice of denial to an applicant by certified mail or personal service.  
447.17 In the notice of denial, the commissioner must state the reasons that the commissioner denied  
447.18 the application and must inform the applicant of the applicant's right to request a contested  
447.19 case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The  
447.20 applicant may appeal the denial by notifying the commissioner in writing by certified mail  
447.21 or personal service. If mailed, the appeal must be postmarked and sent to the commissioner  
447.22 within 20 calendar days after the applicant received the notice of denial. If an applicant  
447.23 delivers an appeal by personal service, the commissioner must receive the appeal within 20  
447.24 calendar days after the applicant received the notice of denial.

447.25 (f) The commissioner may require the applicant or certification holder to provide an  
447.26 email address for the certification holder that will be made public subject to the requirements  
447.27 under section 13.46, subdivision 4, paragraph (b), clause (1), item (i).

447.28 Sec. 37. Minnesota Statutes 2022, section 256.9685, subdivision 1a, is amended to read:

447.29 Subd. 1a. **Administrative reconsideration.** Notwithstanding section 256B.04,  
447.30 subdivision 15, the commissioner shall establish an administrative reconsideration process  
447.31 for appeals of inpatient hospital services determined to be medically unnecessary. A  
447.32 physician, advanced practice registered nurse, physician assistant, or hospital may request  
447.33 a reconsideration of the decision that inpatient hospital services are not medically necessary  
447.34 by submitting a written request for review to the commissioner within 30 calendar days

448.1 after receiving the date of the notice of the decision was mailed. The request for  
448.2 reconsideration process shall take place prior to the procedures of subdivision 1b and shall  
448.3 be conducted be reviewed by the at least one medical review agent that is independent of  
448.4 the case under reconsideration. The medical review agent shall make a recommendation to  
448.5 the commissioner. The commissioner's decision on reconsideration is final and not subject  
448.6 to appeal under chapter 14.

448.7 Sec. 38. Minnesota Statutes 2022, section 256.9685, subdivision 1b, is amended to read:

448.8 Subd. 1b. **Appeal of reconsideration.** ~~Notwithstanding section 256B.72, the~~  
448.9 ~~commissioner may recover inpatient hospital payments for services that have been determined~~  
448.10 ~~to be medically unnecessary after the reconsideration and determinations. A physician,~~  
448.11 ~~advanced practice registered nurse, physician assistant, or hospital may appeal the result of~~  
448.12 ~~the reconsideration process by submitting a written request for review to the commissioner~~  
448.13 ~~within 30 days after receiving notice of the action. The commissioner shall review the~~  
448.14 ~~medical record and information submitted during the reconsideration process and the medical~~  
448.15 ~~review agent's basis for the determination that the services were not medically necessary~~  
448.16 ~~for inpatient hospital services. The commissioner shall issue an order upholding or reversing~~  
448.17 ~~the decision of the reconsideration process based on the review. The commissioner's decision~~  
448.18 under subdivision 1a is appealable by petition for writ of certiorari under chapter 606.

448.19 Sec. 39. Minnesota Statutes 2022, section 256.9686, is amended by adding a subdivision  
448.20 to read:

448.21 Subd. 7a. **Medical review agent.** "Medical review agent" means the representative of  
448.22 the commissioner who is authorized by the commissioner to administer medical record  
448.23 reviews; conduct administrative reconsiderations as defined by section 256.9685, subdivision  
448.24 1a; and perform other functions as stipulated in the terms of the agent's contract with the  
448.25 department. Medical records reviews and administrative reconsiderations will be performed  
448.26 by medical professionals within their scope of expertise, including but not limited to  
448.27 physicians, physician assistants, advanced practice registered nurses, and registered nurses.  
448.28 The medical professional performing the review or reconsideration must be on staff with  
448.29 the medical review agent, in good standing, and licensed to practice in the state where the  
448.30 medical professional resides.

448.31 Sec. 40. Minnesota Statutes 2022, section 256B.04, subdivision 15, is amended to read:

448.32 Subd. 15. **Utilization review.** (a) Establish on a statewide basis a new program to  
448.33 safeguard against unnecessary or inappropriate use of medical assistance services, against

449.1 excess payments, against unnecessary or inappropriate hospital admissions or lengths of  
449.2 stay, and against underutilization of services in prepaid health plans, long-term care facilities  
449.3 or any health care delivery system subject to fixed rate reimbursement. In implementing  
449.4 the program, the state agency shall utilize both prepayment and postpayment review systems  
449.5 to determine if utilization is reasonable and necessary. The determination of whether services  
449.6 are reasonable and necessary shall be made by the commissioner in consultation with a  
449.7 professional services advisory group or health care consultant appointed by the commissioner.

449.8 (b) Contracts entered into for purposes of meeting the requirements of this subdivision  
449.9 shall not be subject to the set-aside provisions of chapter 16C.

449.10 (c) A recipient aggrieved by the commissioner's termination of services or denial of  
449.11 future services may appeal pursuant to section 256.045. Unless otherwise provided by law,  
449.12 a vendor aggrieved by the commissioner's determination that services provided were not  
449.13 reasonable or necessary may appeal pursuant to the contested case procedures of chapter  
449.14 14. To appeal, the vendor shall notify the commissioner in writing within 30 days of receiving  
449.15 the commissioner's notice. The appeal request shall specify each disputed item, the reason  
449.16 for the dispute, an estimate of the dollar amount involved for each disputed item, the  
449.17 computation that the vendor believes is correct, the authority in statute or rule upon which  
449.18 the vendor relies for each disputed item, the name and address of the person or firm with  
449.19 whom contacts may be made regarding the appeal, and other information required by the  
449.20 commissioner.

449.21 (d) The commissioner may select providers to provide case management services to  
449.22 recipients who use health care services inappropriately or to recipients who are eligible for  
449.23 other managed care projects. The providers shall be selected based upon criteria that may  
449.24 include a comparison with a peer group of providers related to the quality, quantity, or cost  
449.25 of health care services delivered or a review of sanctions previously imposed by health care  
449.26 services programs or the provider's professional licensing board.

449.27 Sec. 41. Minnesota Statutes 2022, section 256B.064, is amended to read:

449.28 **256B.064 SANCTIONS; MONETARY RECOVERY.**

449.29 Subdivision 1. **Terminating payments to ineligible vendors individuals or entities.** The  
449.30 commissioner may terminate payments under this chapter to any person or facility that,  
449.31 under applicable federal law or regulation, has been determined to be ineligible for payments  
449.32 under title XIX of the Social Security Act.

450.1 Subd. 1a. **Grounds for sanctions against vendors.** (a) The commissioner may impose  
450.2 sanctions against ~~a vendor of medical care~~ any individual or entity that receives payments  
450.3 from medical assistance or provides goods or services for which payment is made from  
450.4 medical assistance for any of the following: (1) fraud, theft, or abuse in connection with the  
450.5 provision of ~~medical care~~ goods and services to recipients of public assistance for which  
450.6 payment is made from medical assistance; (2) a pattern of presentment of false or duplicate  
450.7 claims or claims for services not medically necessary; (3) a pattern of making false statements  
450.8 of material facts for the purpose of obtaining greater compensation than that to which the  
450.9 ~~vendor~~ individual or entity is legally entitled; (4) suspension or termination as a Medicare  
450.10 vendor; (5) refusal to grant the state agency access during regular business hours to examine  
450.11 all records necessary to disclose the extent of services provided to program recipients and  
450.12 appropriateness of claims for payment; (6) failure to repay an overpayment or a fine finally  
450.13 established under this section; (7) failure to correct errors in the maintenance of health  
450.14 service or financial records for which a fine was imposed or after issuance of a warning by  
450.15 the commissioner; and (8) any reason for which ~~a vendor~~ an individual or entity could be  
450.16 excluded from participation in the Medicare program under section 1128, 1128A, or  
450.17 1866(b)(2) of the Social Security Act. For the purposes of this section, goods or services  
450.18 for which payment is made from medical assistance includes but is not limited to care and  
450.19 services identified in section 256B.0625 or provided pursuant to any federally approved  
450.20 waiver.

450.21 (b) The commissioner may impose sanctions against a pharmacy provider for failure to  
450.22 respond to a cost of dispensing survey under section 256B.0625, subdivision 13e, paragraph  
450.23 (h).

450.24 Subd. 1b. **Sanctions available.** The commissioner may impose the following sanctions  
450.25 for the conduct described in subdivision 1a: suspension or withholding of payments to a  
450.26 ~~vendor~~ an individual or entity and suspending or terminating participation in the program,  
450.27 or imposition of a fine under subdivision 2, paragraph (f). When imposing sanctions under  
450.28 this section, the commissioner shall consider the nature, chronicity, or severity of the conduct  
450.29 and the effect of the conduct on the health and safety of persons served by the ~~vendor~~  
450.30 individual or entity. The commissioner shall suspend ~~a vendor's~~ an individual's or entity's  
450.31 participation in the program for a minimum of five years if the ~~vendor~~ individual or entity  
450.32 is convicted of a crime, received a stay of adjudication, or entered a court-ordered diversion  
450.33 program for an offense related to a provision of a health service under medical assistance,  
450.34 including a federally approved waiver, or health care fraud. Regardless of imposition of  
450.35 sanctions, the commissioner may make a referral to the appropriate state licensing board.

451.1 Subd. 1c. **Grounds for and methods of monetary recovery.** (a) The commissioner  
451.2 may obtain monetary recovery from ~~a vendor who~~ an individual or entity that has been  
451.3 improperly paid by the department either as a result of conduct described in subdivision 1a  
451.4 or as a result of ~~a vendor or department~~ an error by the individual or entity submitting the  
451.5 claim or by the department, regardless of whether the error was intentional. Patterns need  
451.6 not be proven as a precondition to monetary recovery of erroneous or false claims, duplicate  
451.7 claims, claims for services not medically necessary, or claims based on false statements.

451.8 (b) The commissioner may obtain monetary recovery using methods including but not  
451.9 limited to the following: assessing and recovering money improperly paid and debiting from  
451.10 future payments any money improperly paid. The commissioner shall charge interest on  
451.11 money to be recovered if the recovery is to be made by installment payments or debits,  
451.12 except when the monetary recovery is of an overpayment that resulted from a department  
451.13 error. The interest charged shall be the rate established by the commissioner of revenue  
451.14 under section 270C.40.

451.15 Subd. 1d. **Investigative costs.** The commissioner may seek recovery of investigative  
451.16 costs from any ~~vendor of medical care or services who~~ individual or entity that willfully  
451.17 submits a claim for reimbursement for services that the ~~vendor~~ individual or entity knows,  
451.18 or reasonably should have known, is a false representation and that results in the payment  
451.19 of public funds for which the ~~vendor~~ individual or entity is ineligible. Billing errors that  
451.20 result in unintentional overcharges shall not be grounds for investigative cost recoupment.

451.21 Subd. 2. **Imposition of monetary recovery and sanctions.** (a) The commissioner shall  
451.22 determine any monetary amounts to be recovered and sanctions to be imposed upon ~~a vendor~~  
451.23 ~~of medical care~~ an individual or entity under this section. Except as provided in paragraphs  
451.24 (b) and (d), neither a monetary recovery nor a sanction will be imposed by the commissioner  
451.25 without prior notice and an opportunity for a hearing, according to chapter 14, on the  
451.26 commissioner's proposed action, provided that the commissioner may suspend or reduce  
451.27 payment to ~~a vendor of medical care~~ an individual or entity, except a nursing home or  
451.28 convalescent care facility, after notice and prior to the hearing if in the commissioner's  
451.29 opinion that action is necessary to protect the public welfare and the interests of the program.

451.30 (b) Except when the commissioner finds good cause not to suspend payments under  
451.31 Code of Federal Regulations, title 42, section 455.23 (e) or (f), the commissioner shall  
451.32 withhold or reduce payments to ~~a vendor of medical care~~ an individual or entity without  
451.33 providing advance notice of such withholding or reduction if either of the following occurs:

452.1 (1) the ~~vendor~~ individual or entity is convicted of a crime involving the conduct described  
452.2 in subdivision 1a; or

452.3 (2) the commissioner determines there is a credible allegation of fraud for which an  
452.4 investigation is pending under the program. Allegations are considered credible when they  
452.5 have an indicium of reliability and the state agency has reviewed all allegations, facts, and  
452.6 evidence carefully and acts judiciously on a case-by-case basis. A credible allegation of  
452.7 fraud is an allegation which has been verified by the state, from any source, including but  
452.8 not limited to:

452.9 (i) fraud hotline complaints;

452.10 (ii) claims data mining; and

452.11 (iii) patterns identified through provider audits, civil false claims cases, and law  
452.12 enforcement investigations.

452.13 ~~Allegations are considered to be credible when they have an indicia of reliability and~~  
452.14 ~~the state agency has reviewed all allegations, facts, and evidence carefully and acts~~  
452.15 ~~judiciously on a case-by-case basis.~~

452.16 (c) The commissioner must send notice of the withholding or reduction of payments  
452.17 under paragraph (b) within five days of taking such action unless requested in writing by a  
452.18 law enforcement agency to temporarily withhold the notice. The notice must:

452.19 (1) state that payments are being withheld according to paragraph (b);

452.20 (2) set forth the general allegations as to the nature of the withholding action, but need  
452.21 not disclose any specific information concerning an ongoing investigation;

452.22 (3) except in the case of a conviction for conduct described in subdivision 1a, state that  
452.23 the withholding is for a temporary period and cite the circumstances under which withholding  
452.24 will be terminated;

452.25 (4) identify the types of claims to which the withholding applies; and

452.26 (5) inform the ~~vendor~~ individual or entity of the right to submit written evidence for  
452.27 consideration by the commissioner.

452.28 (d) The withholding or reduction of payments will not continue after the commissioner  
452.29 determines there is insufficient evidence of fraud by the ~~vendor~~ individual or entity, or after  
452.30 legal proceedings relating to the alleged fraud are completed, unless the commissioner has  
452.31 sent notice of intention to impose monetary recovery or sanctions under paragraph (a). Upon  
452.32 conviction for a crime related to the provision, management, or administration of a health

453.1 service under medical assistance, a payment held pursuant to this section by the commissioner  
453.2 or a managed care organization that contracts with the commissioner under section 256B.035  
453.3 is forfeited to the commissioner or managed care organization, regardless of the amount  
453.4 charged in the criminal complaint or the amount of criminal restitution ordered.

453.5 ~~(d)~~ (e) The commissioner shall suspend or terminate a ~~vendor's~~ an individual's or entity's  
453.6 participation in the program without providing advance notice and an opportunity for a  
453.7 hearing when the suspension or termination is required because of the ~~vendor's~~ individual's  
453.8 or entity's exclusion from participation in Medicare. Within five days of taking such action,  
453.9 the commissioner must send notice of the suspension or termination. The notice must:

453.10 (1) state that suspension or termination is the result of the ~~vendor's~~ individual's or entity's  
453.11 exclusion from Medicare;

453.12 (2) identify the effective date of the suspension or termination; and

453.13 (3) inform the ~~vendor~~ individual or entity of the need to be reinstated to Medicare before  
453.14 reapplying for participation in the program.

453.15 ~~(e)~~ (f) Upon receipt of a notice under paragraph (a) that a monetary recovery or sanction  
453.16 is to be imposed, a ~~vendor~~ an individual or entity may request a contested case, as defined  
453.17 in section 14.02, subdivision 3, by filing with the commissioner a written request of appeal.  
453.18 The appeal request must be received by the commissioner no later than 30 days after the  
453.19 date the notification of monetary recovery or sanction was mailed to the ~~vendor~~ individual  
453.20 or entity. The appeal request must specify:

453.21 (1) each disputed item, the reason for the dispute, and an estimate of the dollar amount  
453.22 involved for each disputed item;

453.23 (2) the computation that the ~~vendor~~ individual or entity believes is correct;

453.24 (3) the authority in statute or rule upon which the ~~vendor~~ individual or entity relies for  
453.25 each disputed item;

453.26 (4) the name and address of the person or entity with whom contacts may be made  
453.27 regarding the appeal; and

453.28 (5) other information required by the commissioner.

453.29 ~~(f)~~ (g) The commissioner may order a ~~vendor~~ an individual or entity to forfeit a fine for  
453.30 failure to fully document services according to standards in this chapter and Minnesota  
453.31 Rules, chapter 9505. The commissioner may assess fines if specific required components  
453.32 of documentation are missing. The fine for incomplete documentation shall equal 20 percent

454.1 of the amount paid on the claims for reimbursement submitted by the ~~vendor~~ individual or  
454.2 entity, or up to \$5,000, whichever is less. If the commissioner determines that a ~~vendor~~ an  
454.3 individual or entity repeatedly violated this chapter, chapter 254B or 245G, or Minnesota  
454.4 Rules, chapter 9505, related to the provision of services to program recipients and the  
454.5 submission of claims for payment, the commissioner may order a ~~vendor~~ an individual or  
454.6 entity to forfeit a fine based on the nature, severity, and chronicity of the violations, in an  
454.7 amount of up to \$5,000 or 20 percent of the value of the claims, whichever is greater. The  
454.8 commissioner may issue fines under this paragraph in place of or in addition to full monetary  
454.9 recovery of the value of the claims submitted under subdivision 1c.

454.10 ~~(g)~~ (h) The ~~vendor~~ individual or entity shall pay the fine assessed on or before the  
454.11 payment date specified. If the ~~vendor~~ individual or entity fails to pay the fine, the  
454.12 commissioner may withhold or reduce payments and recover the amount of the fine. A  
454.13 timely appeal shall stay payment of the fine until the commissioner issues a final order.

454.14 Subd. 3. **~~Vendor~~ Mandates on prohibited payments.** (a) The commissioner shall  
454.15 maintain and publish a list of each excluded individual and entity that was convicted of a  
454.16 crime related to the provision, management, or administration of a medical assistance health  
454.17 service, or suspended or terminated under subdivision 2. Medical assistance payments cannot  
454.18 be made by a ~~vendor~~ an individual or entity for items or services furnished either directly  
454.19 or indirectly by an excluded individual or entity, or at the direction of excluded individuals  
454.20 or entities.

454.21 (b) The ~~vendor~~ entity must check the exclusion list on a monthly basis and document  
454.22 the date and time the exclusion list was checked and the name and title of the person who  
454.23 checked the exclusion list. The ~~vendor~~ entity must immediately terminate payments to an  
454.24 individual or entity on the exclusion list.

454.25 (c) ~~A vendor's~~ An entity's requirement to check the exclusion list and to terminate  
454.26 payments to individuals or entities on the exclusion list applies to each individual or entity  
454.27 on the exclusion list, even if the named individual or entity is not responsible for direct  
454.28 patient care or direct submission of a claim to medical assistance.

454.29 (d) ~~A vendor~~ An entity that pays medical assistance program funds to an individual or  
454.30 entity on the exclusion list must refund any payment related to either items or services  
454.31 rendered by an individual or entity on the exclusion list from the date the individual or entity  
454.32 is first paid or the date the individual or entity is placed on the exclusion list, whichever is  
454.33 later, and a ~~vendor~~ an entity may be subject to:

454.34 (1) sanctions under subdivision 2;

455.1 (2) a civil monetary penalty of up to \$25,000 for each determination by the department  
455.2 that the vendor employed or contracted with an individual or entity on the exclusion list;  
455.3 and

455.4 (3) other fines or penalties allowed by law.

455.5 Subd. 4. **Notice.** (a) The department shall serve the notice required under subdivision 2  
455.6 ~~shall be served~~ by certified mail at the address submitted to the department by the ~~vendor~~  
455.7 individual or entity. Service is complete upon mailing. ~~The commissioner shall place an~~  
455.8 ~~affidavit of the certified mailing in the vendor's file as an indication of the address and the~~  
455.9 ~~date of mailing.~~

455.10 (b) The department shall give notice in writing to a recipient placed in the Minnesota  
455.11 restricted recipient program under section 256B.0646 and Minnesota Rules, part 9505.2200.  
455.12 The department shall send the notice ~~shall be sent~~ by first class mail to the recipient's current  
455.13 address on file with the department. A recipient placed in the Minnesota restricted recipient  
455.14 program may contest the placement by submitting a written request for a hearing to the  
455.15 department within 90 days of the notice being mailed.

455.16 Subd. 5. **Immunity; good faith reporters.** (a) A person who makes a good faith report  
455.17 is immune from any civil or criminal liability that might otherwise arise from reporting or  
455.18 participating in the investigation. Nothing in this subdivision affects ~~a vendor's~~ an individual's  
455.19 or entity's responsibility for an overpayment established under this subdivision.

455.20 (b) A person employed by a lead investigative agency who is conducting or supervising  
455.21 an investigation or enforcing the law according to the applicable law or rule is immune from  
455.22 any civil or criminal liability that might otherwise arise from the person's actions, if the  
455.23 person is acting in good faith and exercising due care.

455.24 (c) For purposes of this subdivision, "person" includes a natural person or any form of  
455.25 a business or legal entity.

455.26 (d) After an investigation is complete, the reporter's name must be kept confidential.  
455.27 The subject of the report may compel disclosure of the reporter's name only with the consent  
455.28 of the reporter or upon a written finding by a district court that the report was false and there  
455.29 is evidence that the report was made in bad faith. This subdivision does not alter disclosure  
455.30 responsibilities or obligations under the Rules of Criminal Procedure, except that when the  
455.31 identity of the reporter is relevant to a criminal prosecution the district court shall conduct  
455.32 an in-camera review before determining whether to order disclosure of the reporter's identity.

456.1 Sec. 42. Minnesota Statutes 2022, section 256B.27, subdivision 3, is amended to read:

456.2 Subd. 3. **Access to medical records.** The commissioner of human services, with the  
456.3 written consent of the recipient, on file with the local welfare agency, shall be allowed  
456.4 access in the manner and within the time prescribed by the commissioner to all personal  
456.5 medical records of medical assistance recipients solely for the purposes of investigating  
456.6 whether or not: (a) a vendor of medical care has submitted a claim for reimbursement, a  
456.7 cost report or a rate application which is duplicative, erroneous, or false in whole or in part,  
456.8 or which results in the vendor obtaining greater compensation than the vendor is legally  
456.9 entitled to; or (b) the medical care was medically necessary. When the commissioner is  
456.10 investigating a possible overpayment of Medicaid funds, the commissioner must be given  
456.11 immediate access without prior notice to the vendor's office during regular business hours  
456.12 and to documentation and records related to services provided and submission of claims  
456.13 for services provided. The department shall document in writing the need for immediate  
456.14 access to records related to a specific investigation. Denying the commissioner access to  
456.15 records is cause for the vendor's immediate suspension of payment or termination according  
456.16 to section 256B.064. All providers receiving medical assistance payments must make those  
456.17 records available immediately to the commissioner upon request. Any records not provided  
456.18 to the commissioner at the date and time of the request are inadmissible if offered as evidence  
456.19 by the provider in any proceeding to contest sanctions against or monetary recovery from  
456.20 the provider. The determination of provision of services not medically necessary shall be  
456.21 made by the commissioner. Notwithstanding any other law to the contrary, a vendor of  
456.22 medical care shall not be subject to any civil or criminal liability for providing access to  
456.23 medical records to the commissioner of human services pursuant to this section.

456.24 Sec. 43. Minnesota Statutes 2022, section 524.5-118, subdivision 2a, is amended to read:

456.25 Subd. 2a. **Procedure; state licensing agency data.** (a) The court shall request the  
456.26 commissioner of human services to provide the court within 25 working days of receipt of  
456.27 the request with licensing agency data for licenses directly related to the responsibilities of  
456.28 a professional fiduciary if the study subject indicates current or prior affiliation from the  
456.29 following agencies in Minnesota:

456.30 (1) Lawyers Responsibility Board;

456.31 (2) State Board of Accountancy;

456.32 (3) Board of Social Work;

456.33 (4) Board of Psychology;

- 457.1 (5) Board of Nursing;
- 457.2 (6) Board of Medical Practice;
- 457.3 ~~(7) Department of Education;~~
- 457.4 ~~(8)~~ (7) Department of Commerce;
- 457.5 ~~(9)~~ (8) Board of Chiropractic Examiners;
- 457.6 ~~(10)~~ (9) Board of Dentistry;
- 457.7 ~~(11)~~ (10) Board of Marriage and Family Therapy;
- 457.8 ~~(12)~~ (11) Department of Human Services;
- 457.9 ~~(13)~~ (12) Peace Officer Standards and Training (POST) Board; and
- 457.10 ~~(14)~~ (13) Professional Educator Licensing and Standards Board.

457.11 (b) The commissioner shall enter into agreements with these agencies to provide the  
457.12 commissioner with electronic access to the relevant licensing data, and to provide the  
457.13 commissioner with a quarterly list of new sanctions issued by the agency.

457.14 (c) The commissioner shall provide to the court the electronically available data  
457.15 maintained in the agency's database, including whether the proposed guardian or conservator  
457.16 is or has been licensed by the agency, and if the licensing agency database indicates a  
457.17 disciplinary action or a sanction against the individual's license, including a condition,  
457.18 suspension, revocation, or cancellation.

457.19 (d) If the proposed guardian or conservator has resided in a state other than Minnesota  
457.20 in the previous ten years, licensing agency data under this section shall also include the  
457.21 licensing agency data from any other state where the proposed guardian or conservator  
457.22 reported to have resided during the previous ten years if the study subject indicates current  
457.23 or prior affiliation. If the proposed guardian or conservator has or has had a professional  
457.24 license in another state that is directly related to the responsibilities of a professional fiduciary  
457.25 from one of the agencies listed under paragraph (a), state licensing agency data shall also  
457.26 include data from the relevant licensing agency of that state.

457.27 (e) The commissioner is not required to repeat a search for Minnesota or out-of-state  
457.28 licensing data on an individual if the commissioner has provided this information to the  
457.29 court within the prior five years.

458.1 (f) The commissioner shall review the information in paragraph (c) at least once every  
458.2 four months to determine if an individual who has been studied within the previous five  
458.3 years:

458.4 (1) has new disciplinary action or sanction against the individual's license; or

458.5 (2) did not disclose a prior or current affiliation with a Minnesota licensing agency.

458.6 (g) If the commissioner's review in paragraph (f) identifies new information, the  
458.7 commissioner shall provide any new information to the court.

458.8 Sec. 44. REVISOR INSTRUCTION.

458.9 The revisor of statutes shall renumber the subdivisions in Minnesota Statutes, section  
458.10 245C.02, in alphabetical order and correct any cross-reference changes that result.

458.11 Sec. 45. REPEALER.

458.12 (a) Minnesota Statutes 2022, sections 245A.22; 245C.02, subdivision 9; 245C.301; and  
458.13 256.9685, subdivisions 1c and 1d, are repealed.

458.14 (b) Minnesota Rules, parts 9505.0505, subpart 18; and 9505.0520, subpart 9b, are  
458.15 repealed.

458.16 EFFECTIVE DATE. This section is effective the day following final enactment.

458.17 **ARTICLE 10**  
458.18 **ECONOMIC ASSISTANCE**

458.19 Section 1. Minnesota Statutes 2022, section 256D.01, subdivision 1a, is amended to read:

458.20 Subd. 1a. **Standards.** (a) A principal objective in providing general assistance is to  
458.21 provide for single adults, childless couples, or children as defined in section 256D.02,  
458.22 subdivision 6, ineligible for federal programs who are unable to provide for themselves.  
458.23 The minimum standard of assistance determines the total amount of the general assistance  
458.24 grant without separate standards for shelter, utilities, or other needs.

458.25 (b) ~~The commissioner shall set the standard of assistance for an assistance unit consisting~~  
458.26 ~~of an adult a recipient who is childless and unmarried or living apart from children and~~  
458.27 ~~spouse and who does not live with a parent or parents or a legal custodian~~ is the cash portion  
458.28 of the MFIP transitional standard for a single adult under section 256J.24, subdivision 5.  
458.29 ~~When the other standards specified in this subdivision increase, this standard must also be~~  
458.30 ~~increased by the same percentage.~~

459.1 (c) For an assistance unit consisting of a single adult who lives with a parent or parents,  
459.2 the general assistance standard of assistance ~~is the amount that the aid to families with~~  
459.3 ~~dependent children standard of assistance, in effect on July 16, 1996, would increase if the~~  
459.4 ~~recipient were added as an additional minor child to an assistance unit consisting of the~~  
459.5 ~~recipient's parent and all of that parent's family members, except that the standard may not~~  
459.6 ~~exceed the standard for a general assistance recipient living alone~~ is the cash portion of the  
459.7 MFIP transitional standard for a single adult under section 256J.24, subdivision 5. Benefits  
459.8 received by a responsible relative of the assistance unit under the Supplemental Security  
459.9 Income program, a workers' compensation program, the Minnesota supplemental aid program,  
459.10 or any other program based on the responsible relative's disability, and any benefits received  
459.11 by a responsible relative of the assistance unit under the Social Security retirement program,  
459.12 may not be counted in the determination of eligibility or benefit level for the assistance unit.  
459.13 Except as provided below, the assistance unit is ineligible for general assistance if the  
459.14 available resources or the countable income of the assistance unit and the parent or parents  
459.15 with whom the assistance unit lives are such that a family consisting of the assistance unit's  
459.16 parent or parents, the parent or parents' other family members and the assistance unit as the  
459.17 only or additional minor child would be financially ineligible for general assistance. For  
459.18 the purposes of calculating the countable income of the assistance unit's parent or parents,  
459.19 the calculation methods must follow the provisions under section 256P.06.

459.20 (d) For an assistance unit consisting of a childless couple, the standards of assistance  
459.21 are the same as the first and second adult standards of the aid to families with dependent  
459.22 children program in effect on July 16, 1996. If one member of the couple is not included in  
459.23 the general assistance grant, the standard of assistance for the other is the second adult  
459.24 standard of the aid to families with dependent children program as of July 16, 1996.

459.25 Sec. 2. Minnesota Statutes 2022, section 256D.024, subdivision 1, is amended to read:

459.26 Subdivision 1. **Person convicted of drug offenses.** (a) ~~If An applicant or recipient~~  
459.27 individual who has been convicted of a felony-level drug offense ~~after July 1, 1997, the~~  
459.28 ~~assistance unit is ineligible for benefits under this chapter until five years after the applicant~~  
459.29 ~~has completed terms of the court-ordered sentence, unless the person is participating in a~~  
459.30 ~~drug treatment program, has successfully completed a drug treatment program, or has been~~  
459.31 ~~assessed by the county and determined not to be in need of a drug treatment program. Persons~~  
459.32 ~~subject to the limitations of this subdivision who become eligible for assistance under this~~  
459.33 ~~chapter shall~~ during the previous ten years from the date of application or recertification  
459.34 may be subject to random drug testing as a condition of continued eligibility and shall lose  
459.35 eligibility for benefits for five years beginning the month following. The county must

460.1 provide information about substance use disorder treatment programs to a person who tests  
460.2 positive for an illegal controlled substance.

460.3 ~~(1) Any positive test result for an illegal controlled substance; or~~

460.4 ~~(2) discharge of sentence after conviction for another drug felony.~~

460.5 (b) For the purposes of this subdivision, "drug offense" means a conviction that occurred  
460.6 after July 1, 1997, during the previous ten years from the date of application or recertification  
460.7 of sections 152.021 to 152.025, 152.0261, 152.0262, or 152.096. Drug offense also means  
460.8 a conviction in another jurisdiction of the possession, use, or distribution of a controlled  
460.9 substance, or conspiracy to commit any of these offenses, if the offense conviction occurred  
460.10 after July 1, 1997, during the previous ten years from the date of application or recertification  
460.11 and the conviction is a felony offense in that jurisdiction, or in the case of New Jersey, a  
460.12 high misdemeanor.

460.13 **EFFECTIVE DATE.** This section is effective August 1, 2023.

460.14 Sec. 3. Minnesota Statutes 2022, section 256D.06, subdivision 5, is amended to read:

460.15 Subd. 5. **Eligibility; requirements.** (a) Any applicant, otherwise eligible for general  
460.16 assistance and possibly eligible for maintenance benefits from any other source shall (1)  
460.17 make application for those benefits within ~~30~~ 90 days of the general assistance application;  
460.18 and (2) execute an interim assistance agreement on a form as directed by the commissioner.

460.19 (b) The commissioner shall review a denial of an application for other maintenance  
460.20 benefits and may require a recipient of general assistance to file an appeal of the denial if  
460.21 appropriate. If found eligible for benefits from other sources, and a payment received from  
460.22 another source relates to the period during which general assistance was also being received,  
460.23 the recipient shall be required to reimburse the county agency for the interim assistance  
460.24 paid. Reimbursement shall not exceed the amount of general assistance paid during the time  
460.25 period to which the other maintenance benefits apply and shall not exceed the state standard  
460.26 applicable to that time period.

460.27 (c) The commissioner may contract with the county agencies, qualified agencies,  
460.28 organizations, or persons to provide advocacy and support services to process claims for  
460.29 federal disability benefits for applicants or recipients of services or benefits supervised by  
460.30 the commissioner using money retained under this section.

460.31 (d) The commissioner may provide methods by which county agencies shall identify,  
460.32 refer, and assist recipients who may be eligible for benefits under federal programs for  
460.33 people with a disability.

461.1 (e) The total amount of interim assistance recoveries retained under this section for  
461.2 advocacy, support, and claim processing services shall not exceed 35 percent of the interim  
461.3 assistance recoveries in the prior fiscal year.

461.4 Sec. 4. Minnesota Statutes 2022, section 256J.26, subdivision 1, is amended to read:

461.5 Subdivision 1. **Person convicted of drug offenses.** (a) An individual who has been  
461.6 convicted of a felony level drug offense committed during the previous ten years from the  
461.7 date of application or recertification is subject to the following:

461.8 (1) Benefits for the entire assistance unit must be paid in vendor form for shelter and  
461.9 utilities during any time the applicant is part of the assistance unit.

461.10 (2) The convicted applicant or participant ~~shall~~ may be subject to random drug testing  
461.11 ~~as a condition of continued eligibility and.~~ Following any positive test for an illegal controlled  
461.12 ~~substance is subject to the following sanctions:~~ the county must provide information about  
461.13 substance use disorder treatment programs to the applicant or participant.

461.14 ~~(i) for failing a drug test the first time, the residual amount of the participant's grant after~~  
461.15 ~~making vendor payments for shelter and utility costs, if any, must be reduced by an amount~~  
461.16 ~~equal to 30 percent of the MFIP standard of need for an assistance unit of the same size.~~  
461.17 ~~When a sanction under this subdivision is in effect, the job counselor must attempt to meet~~  
461.18 ~~with the person face-to-face. During the face-to-face meeting, the job counselor must explain~~  
461.19 ~~the consequences of a subsequent drug test failure and inform the participant of the right to~~  
461.20 ~~appeal the sanction under section 256J.40. If a face-to-face meeting is not possible, the~~  
461.21 ~~county agency must send the participant a notice of adverse action as provided in section~~  
461.22 ~~256J.31, subdivisions 4 and 5, and must include the information required in the face-to-face~~  
461.23 ~~meeting; or~~

461.24 ~~(ii) for failing a drug test two times, the participant is permanently disqualified from~~  
461.25 ~~receiving MFIP assistance, both the cash and food portions. The assistance unit's MFIP~~  
461.26 ~~grant must be reduced by the amount which would have otherwise been made available to~~  
461.27 ~~the disqualified participant. Disqualification under this item does not make a participant~~  
461.28 ~~ineligible for the Supplemental Nutrition Assistance Program (SNAP). Before a~~  
461.29 ~~disqualification under this provision is imposed, the job counselor must attempt to meet~~  
461.30 ~~with the participant face-to-face. During the face-to-face meeting, the job counselor must~~  
461.31 ~~identify other resources that may be available to the participant to meet the needs of the~~  
461.32 ~~family and inform the participant of the right to appeal the disqualification under section~~  
461.33 ~~256J.40. If a face-to-face meeting is not possible, the county agency must send the participant~~

462.1 ~~a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5, and must~~  
462.2 ~~include the information required in the face-to-face meeting.~~

462.3 ~~(3) A participant who fails a drug test the first time and is under a sanction due to other~~  
462.4 ~~MFIP program requirements is considered to have more than one occurrence of~~  
462.5 ~~noncompliance and is subject to the applicable level of sanction as specified under section~~  
462.6 ~~256J.46, subdivision 1, paragraph (d).~~

462.7 (b) Applicants requesting only SNAP benefits or participants receiving only SNAP  
462.8 benefits, who have been convicted of a felony-level drug offense that occurred after July  
462.9 1, 1997, during the previous ten years from the date of application or recertification may,  
462.10 if otherwise eligible, receive SNAP benefits ~~if~~. The convicted applicant or participant is  
462.11 may be subject to random drug testing as a condition of continued eligibility. Following a  
462.12 positive test for an illegal controlled substance, the ~~applicant is subject to the following~~  
462.13 ~~sanctions:~~ county must provide information about substance use disorder treatment programs  
462.14 to the applicant or participant.

462.15 ~~(1) for failing a drug test the first time, SNAP benefits shall be reduced by an amount~~  
462.16 ~~equal to 30 percent of the applicable SNAP benefit allotment. When a sanction under this~~  
462.17 ~~clause is in effect, a job counselor must attempt to meet with the person face-to-face. During~~  
462.18 ~~the face-to-face meeting, a job counselor must explain the consequences of a subsequent~~  
462.19 ~~drug test failure and inform the participant of the right to appeal the sanction under section~~  
462.20 ~~256J.40. If a face-to-face meeting is not possible, a county agency must send the participant~~  
462.21 ~~a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5, and must~~  
462.22 ~~include the information required in the face-to-face meeting; and~~

462.23 ~~(2) for failing a drug test two times, the participant is permanently disqualified from~~  
462.24 ~~receiving SNAP benefits. Before a disqualification under this provision is imposed, a job~~  
462.25 ~~counselor must attempt to meet with the participant face-to-face. During the face-to-face~~  
462.26 ~~meeting, the job counselor must identify other resources that may be available to the~~  
462.27 ~~participant to meet the needs of the family and inform the participant of the right to appeal~~  
462.28 ~~the disqualification under section 256J.40. If a face-to-face meeting is not possible, a county~~  
462.29 ~~agency must send the participant a notice of adverse action as provided in section 256J.31,~~  
462.30 ~~subdivisions 4 and 5, and must include the information required in the face-to-face meeting.~~

462.31 (c) For the purposes of this subdivision, "drug offense" means ~~an offense~~ a conviction  
462.32 that occurred during the previous ten years from the date of application or recertification  
462.33 of sections 152.021 to 152.025, 152.0261, 152.0262, 152.096, or 152.137. Drug offense  
462.34 also means a conviction in another jurisdiction of the possession, use, or distribution of a

463.1 controlled substance, or conspiracy to commit any of these offenses, if the ~~offense~~ conviction  
463.2 occurred during the previous ten years from the date of application or recertification and  
463.3 the conviction is a felony offense in that jurisdiction, or in the case of New Jersey, a high  
463.4 misdemeanor.

463.5 **EFFECTIVE DATE.** This section is effective August 1, 2023.

463.6 Sec. 5. Minnesota Statutes 2022, section 256P.01, is amended by adding a subdivision to  
463.7 read:

463.8 Subd. 5a. **Lived-experience engagement.** "Lived-experience engagement" means an  
463.9 intentional engagement of people with lived experience by a federal, Tribal, state, county,  
463.10 municipal, or nonprofit human services agency funded in part or in whole by federal, state,  
463.11 local government, Tribal Nation, public, private, or philanthropic funds to gather and share  
463.12 feedback on the impact of human services programs.

463.13 Sec. 6. Minnesota Statutes 2022, section 256P.02, subdivision 2, is amended to read:

463.14 Subd. 2. **Personal property limitations.** The equity value of an assistance unit's personal  
463.15 property listed in clauses (1) to (5) must not exceed \$10,000 for applicants and participants.  
463.16 For purposes of this subdivision, personal property is limited to:

463.17 (1) cash not excluded under subdivision 4;

463.18 (2) bank accounts;

463.19 (3) liquid stocks and bonds that can be readily accessed without a financial penalty;

463.20 (4) vehicles not excluded under subdivision 3; and

463.21 (5) the full value of business accounts used to pay expenses not related to the business.

463.22 Sec. 7. Minnesota Statutes 2022, section 256P.02, is amended by adding a subdivision to  
463.23 read:

463.24 Subd. 4. **Health and human services recipient engagement income.** Income received  
463.25 from lived-experience engagement, as defined in section 256P.01, subdivision 6, shall be  
463.26 excluded when determining the equity value of personal property.

463.27 Sec. 8. Minnesota Statutes 2022, section 256P.06, subdivision 3, is amended to read:

463.28 Subd. 3. **Income inclusions.** The following must be included in determining the income  
463.29 of an assistance unit:

- 464.1 (1) earned income; and
- 464.2 (2) unearned income, which includes:
- 464.3 (i) interest and dividends from investments and savings;
- 464.4 (ii) capital gains as defined by the Internal Revenue Service from any sale of real property;
- 464.5 (iii) proceeds from rent and contract for deed payments in excess of the principal and
- 464.6 interest portion owed on property;
- 464.7 (iv) income from trusts, excluding special needs and supplemental needs trusts;
- 464.8 (v) interest income from loans made by the participant or household;
- 464.9 (vi) cash prizes and winnings;
- 464.10 (vii) unemployment insurance income that is received by an adult member of the
- 464.11 assistance unit unless the individual receiving unemployment insurance income is:
- 464.12 (A) 18 years of age and enrolled in a secondary school; or
- 464.13 (B) 18 or 19 years of age, a caregiver, and is enrolled in school at least half-time;
- 464.14 (viii) retirement, survivors, and disability insurance payments;
- 464.15 (ix) nonrecurring income over \$60 per quarter unless the nonrecurring income is: (A)
- 464.16 from tax refunds, tax rebates, or tax credits; (B) a reimbursement, rebate, award, grant, or
- 464.17 refund of personal or real property or costs or losses incurred when these payments are
- 464.18 made by: a public agency; a court; solicitations through public appeal; a federal, state, or
- 464.19 local unit of government; or a disaster assistance organization; (C) provided as an in-kind
- 464.20 benefit; or (D) earmarked and used for the purpose for which it was intended, subject to
- 464.21 verification requirements under section 256P.04;
- 464.22 (x) retirement benefits;
- 464.23 (xi) cash assistance benefits, as defined by each program in chapters 119B, 256D, 256I,
- 464.24 and 256J;
- 464.25 ~~(xii) Tribal per capita payments unless excluded by federal and state law;~~
- 464.26 ~~(xiii)~~ (xii) income from members of the United States armed forces unless excluded
- 464.27 from income taxes according to federal or state law;
- 464.28 ~~(xiv)~~ (xiii) all child support payments for programs under chapters 119B, 256D, and
- 464.29 256I;

465.1 ~~(xv)~~ (xiv) the amount of child support received that exceeds \$100 for assistance units  
465.2 with one child and \$200 for assistance units with two or more children for programs under  
465.3 chapter 256J;

465.4 ~~(xvi)~~ (xv) spousal support; and

465.5 ~~(xvii)~~ (xvi) workers' compensation.

465.6 Sec. 9. Minnesota Statutes 2022, section 256P.06, is amended by adding a subdivision to  
465.7 read:

465.8 Subd. 4. Recipient engagement income. Income received from lived-experience  
465.9 engagement, as defined in section 256P.01, subdivision 5a, must not be counted as income  
465.10 for purposes of determining or redetermining eligibility or benefits.

465.11 Sec. 10. Minnesota Statutes 2022, section 609B.425, subdivision 2, is amended to read:

465.12 Subd. 2. Benefit eligibility. (a) For general assistance benefits and Minnesota  
465.13 supplemental aid under chapter 256D, a person convicted of a felony-level drug offense  
465.14 after July 1, 1997, is ineligible for general assistance benefits and Supplemental Security  
465.15 Income under chapter 256D until: during the previous ten years from the date of application  
465.16 or recertification may be subject to random drug testing. The county must provide information  
465.17 about substance use disorder treatment programs to a person who tests positive for an illegal  
465.18 controlled substance.

465.19 ~~(1) five years after completing the terms of a court-ordered sentence; or~~

465.20 ~~(2) unless the person is participating in a drug treatment program, has successfully~~  
465.21 ~~completed a program, or has been determined not to be in need of a drug treatment program.~~

465.22 ~~(b) A person who becomes eligible for assistance under chapter 256D is subject to~~  
465.23 ~~random drug testing and shall lose eligibility for benefits for five years beginning the month~~  
465.24 ~~following:~~

465.25 ~~(1) any positive test for an illegal controlled substance; or~~

465.26 ~~(2) discharge of sentence for conviction of another drug felony.~~

465.27 ~~(e)~~ (b) Parole violators and fleeing felons are ineligible for benefits and persons  
465.28 fraudulently misrepresenting eligibility are also ineligible to receive benefits for ten years.

465.29 EFFECTIVE DATE. This section is effective August 1, 2023.

466.1 Sec. 11. Minnesota Statutes 2022, section 609B.435, subdivision 2, is amended to read:

466.2 Subd. 2. **Drug offenders; random testing; sanctions.** A person who is an applicant for  
466.3 benefits from the Minnesota family investment program or MFIP, the vehicle for temporary  
466.4 assistance for needy families or TANF, and who has been convicted of a felony-level drug  
466.5 offense shall may be subject to ~~certain conditions, including random drug testing, in order~~  
466.6 ~~to receive MFIP benefits.~~ Following any positive test for a controlled substance, the ~~convicted~~  
466.7 ~~applicant or participant is subject to the following sanctions:~~ county must provide information  
466.8 about substance use disorder treatment programs to the applicant or participant.

466.9 ~~(1) a first time drug test failure results in a reduction of benefits in an amount equal to~~  
466.10 ~~30 percent of the MFIP standard of need; and~~

466.11 ~~(2) a second time drug test failure results in permanent disqualification from receiving~~  
466.12 ~~MFIP assistance.~~

466.13 ~~A similar disqualification sequence occurs if the applicant is receiving Supplemental Nutrition~~  
466.14 ~~Assistance Program (SNAP) benefits.~~

466.15 **EFFECTIVE DATE.** This section is effective August 1, 2023.

## 466.16 ARTICLE 11

### 466.17 HOUSING SUPPORTS

466.18 Section 1. Minnesota Statutes 2022, section 256I.03, subdivision 7, is amended to read:

466.19 Subd. 7. **Countable income.** (a) "Countable income" means all income received by an  
466.20 applicant or recipient as described under section 256P.06, less any applicable exclusions or  
466.21 disregards. ~~For a recipient of any cash benefit from the SSI program, countable income~~  
466.22 ~~means the SSI benefit limit in effect at the time the person is a recipient of housing support,~~  
466.23 ~~less the medical assistance personal needs allowance under section 256B.35. If the SSI limit~~  
466.24 ~~or benefit is reduced for a person due to events other than receipt of additional income,~~  
466.25 ~~countable income means actual income less any applicable exclusions and disregards.~~

466.26 (b) For a recipient of any cash benefit from the SSI program who does not live in a  
466.27 setting described in section 256I.04, subdivision 2a, paragraph (b), clause (2), countable  
466.28 income equals the SSI benefit limit in effect at the time the person is a recipient of housing  
466.29 support, less the personal needs allowance under section 256B.35. If the SSI limit or benefit  
466.30 is reduced for a person due to events other than receipt of additional income, countable  
466.31 income equals actual income less any applicable exclusions and disregards.

467.1 (c) For a recipient of any cash benefit from the SSI program who lives in a setting as  
467.2 described in section 256I.04, subdivision 2a, paragraph (b), clause (2), countable income  
467.3 equals 30 percent of the SSI benefit limit in effect at the time a person is a recipient of  
467.4 housing support. If the SSI limit or benefit is reduced for a person due to events other than  
467.5 receipt of additional income, countable income equals 30 percent of the actual income less  
467.6 any applicable exclusions and disregards. For recipients under this paragraph, the personal  
467.7 needs allowance described in section 256B.35 does not apply.

467.8 (d) Notwithstanding the earned income disregard described in section 256P.03, for a  
467.9 recipient of unearned income as defined in section 256P.06, subdivision 3, clause (2), other  
467.10 than SSI and the general assistance personal needs allowance who lives in a setting described  
467.11 in section 256I.04, subdivision 2a, paragraph (b), clause (2), countable income equals 30  
467.12 percent of the recipient's total income after applicable exclusions and disregards. Total  
467.13 income includes any unearned income as defined in section 256P.06 and any earned income  
467.14 in the month the person is a recipient of housing support. For recipients under this paragraph,  
467.15 the personal needs allowance described in section 256B.35 does not apply.

467.16 (e) For a recipient who lives in a setting as described in section 256I.04, subdivision 2a,  
467.17 paragraph (b), clause (2), and receives general assistance, the personal needs allowance  
467.18 described in section 256B.35 is not countable unearned income.

467.19 **EFFECTIVE DATE.** This section is effective October 1, 2024.

467.20 Sec. 2. Minnesota Statutes 2022, section 256I.04, subdivision 1, is amended to read:

467.21 Subdivision 1. **Individual eligibility requirements.** An individual is eligible for and  
467.22 entitled to a housing support payment to be made on the individual's behalf if the agency  
467.23 has approved the setting where the individual will receive housing support and the individual  
467.24 meets the requirements in paragraph (a), (b), ~~or (c)~~, or (d).

467.25 (a) The individual is aged, blind, or is over 18 years of age with a disability as determined  
467.26 under the criteria used by the title II program of the Social Security Act, and meets the  
467.27 resource restrictions and standards of section 256P.02, and the individual's countable income  
467.28 after deducting the (1) exclusions and disregards of the SSI program, (2) the medical  
467.29 assistance personal needs allowance under section 256B.35, and (3) an amount equal to the  
467.30 income actually made available to a community spouse by an elderly waiver participant  
467.31 under the provisions of sections 256B.0575, paragraph (a), clause (4), and 256B.058,  
467.32 subdivision 2, is less than the monthly rate specified in the agency's agreement with the  
467.33 provider of housing support in which the individual resides.

468.1 (b) The individual meets a category of eligibility under section 256D.05, subdivision 1,  
468.2 paragraph (a), clauses (1), (3), (4) to (8), and (13), and paragraph (b), if applicable, and the  
468.3 individual's resources are less than the standards specified by section 256P.02, and the  
468.4 individual's countable income as determined under section 256P.06, less the medical  
468.5 assistance personal needs allowance under section 256B.35 is less than the monthly rate  
468.6 specified in the agency's agreement with the provider of housing support in which the  
468.7 individual resides.

468.8 (c) The individual lacks a fixed, adequate, nighttime residence upon discharge from a  
468.9 residential behavioral health treatment program, as determined by treatment staff from the  
468.10 residential behavioral health treatment program. An individual is eligible under this paragraph  
468.11 for up to three months, including a full or partial month from the individual's move-in date  
468.12 at a setting approved for housing support following discharge from treatment, plus two full  
468.13 months.

468.14 (d) The individual meets the criteria related to establishing a certified disability or  
468.15 disabling condition in paragraph (a) or (b) and lacks a fixed, adequate, nighttime residence  
468.16 upon discharge from a correctional facility, as determined by an authorized representative  
468.17 from a Minnesota-based correctional facility. An individual is eligible under this paragraph  
468.18 for up to three months, including a full or partial month from the individual's move-in date  
468.19 at a setting approved for housing support following release, plus two full months. People  
468.20 who meet the disabling condition criteria established in paragraph (a) or (b) will not have  
468.21 any countable income for the duration of eligibility under this paragraph.

## 468.22 ARTICLE 12

### 468.23 MISCELLANEOUS

468.24 Section 1. Minnesota Statutes 2022, section 62A.30, is amended by adding a subdivision  
468.25 to read:

468.26 Subd. 5. **Mammogram; diagnostic services and testing.** If a health care provider  
468.27 determines an enrollee requires additional diagnostic services or testing after a mammogram,  
468.28 a health plan must provide coverage for the additional diagnostic services or testing with  
468.29 no cost sharing, including co-pay, deductible, or coinsurance.

468.30 **EFFECTIVE DATE.** This section is effective January 1, 2024, and applies to health  
468.31 plans offered, issued, or sold on or after that date.

469.1 Sec. 2. Minnesota Statutes 2022, section 62A.30, is amended by adding a subdivision to  
469.2 read:

469.3 Subd. 6. **Application.** If the application of subdivision 5 before an enrollee has met their  
469.4 health plan's deductible would result in: (1) health savings account ineligibility under United  
469.5 States Code, title 26, section 223; or (2) catastrophic health plan ineligibility under United  
469.6 States Code, title 42, section 18022(e), then subdivision 5 shall apply to diagnostic services  
469.7 or testing only after the enrollee has met their health plan's deductible.

469.8 **EFFECTIVE DATE.** This section is effective January 1, 2024, and applies to health  
469.9 plans offered, issued, or sold on or after that date.

469.10 Sec. 3. **[62Q.481] COST-SHARING FOR PRESCRIPTION DRUGS AND RELATED**  
469.11 **MEDICAL SUPPLIES TO TREAT CHRONIC DISEASE.**

469.12 Subdivision 1. **Cost-sharing limits.** (a) A health plan must limit the amount of any  
469.13 enrollee cost-sharing for prescription drugs prescribed to treat a chronic disease to no more  
469.14 than \$25 per one-month supply for each prescription drug regardless of the amount or type  
469.15 of medication required to fill the prescription and to no more than \$50 per month in total  
469.16 for all related medical supplies. The cost-sharing limit for related medical supplies does not  
469.17 increase with the number of chronic diseases for which an enrollee is treated. Coverage  
469.18 under this section shall not be subject to any deductible.

469.19 (b) If application of this section before an enrollee has met their plan's deductible would  
469.20 result in: (1) health savings account ineligibility under United States Code, title 26, section  
469.21 223; or (2) catastrophic health plan ineligibility under United States Code, title 42, section  
469.22 18022(e), then this section shall apply to that specific prescription drug or related medical  
469.23 supply only after the enrollee has met their plan's deductible.

469.24 Subd. 2. **Definitions.** (a) For purposes of this section, the following definitions apply.

469.25 (b) "Chronic disease" means diabetes, asthma, and allergies requiring the use of  
469.26 epinephrine auto-injectors.

469.27 (c) "Cost-sharing" means co-payments and coinsurance.

469.28 (d) "Related medical supplies" means syringes, insulin pens, insulin pumps, test strips,  
469.29 glucometers, continuous glucose monitors, epinephrine auto-injectors, asthma inhalers, and  
469.30 other medical supply items necessary to effectively and appropriately treat a chronic disease  
469.31 or administer a prescription drug prescribed to treat a chronic disease.

470.1 **EFFECTIVE DATE.** This section is effective January 1, 2024, and applies to health  
470.2 plans offered, issued, or renewed on or after that date.

470.3 Sec. 4. Minnesota Statutes 2022, section 121A.28, is amended to read:

470.4 **121A.28 LAW ENFORCEMENT RECORDS.**

470.5 A law enforcement agency shall provide notice of any drug incident occurring within  
470.6 the agency's jurisdiction, in which the agency has probable cause to believe a student violated  
470.7 section 152.021, 152.022, 152.023, 152.024, 152.025, 152.0262, 152.027, ~~152.092~~, 152.097,  
470.8 or 340A.503, subdivision 1, 2, or 3. The notice shall be in writing and shall be provided,  
470.9 within two weeks after an incident occurs, to the chemical abuse preassessment team in the  
470.10 school where the student is enrolled.

470.11 Sec. 5. Minnesota Statutes 2022, section 151.01, is amended by adding a subdivision to  
470.12 read:

470.13 **Subd. 43. Syringe services provider.** "Syringe services provider" means a  
470.14 community-based public health program that offers cost-free comprehensive harm reduction  
470.15 services which may include: providing sterile needles, syringes, and other injection  
470.16 equipment; making safe disposal containers for needles and syringes available; educating  
470.17 participants and others about overdose prevention, safer injection practices, and infectious  
470.18 disease prevention; providing blood-borne pathogen testing or referrals to blood-borne  
470.19 pathogen testing; offering referrals to substance use disorder treatment, including substance  
470.20 use disorder treatment with medications for opioid use disorder; and providing referrals to  
470.21 medical treatment and services, mental health programs and services, and other social  
470.22 services.

470.23 Sec. 6. Minnesota Statutes 2022, section 151.40, subdivision 1, is amended to read:

470.24 Subdivision 1. **Generally.** It is unlawful for any person to ~~possess, control,~~ manufacture,  
470.25 sell, furnish, dispense, or otherwise dispose of hypodermic syringes or needles or any  
470.26 instrument or implement which can be adapted for subcutaneous injections, except for:

470.27 (1) the following persons when acting in the course of their practice or employment:

470.28 (i) licensed practitioners and their employees, agents, or delegates;

470.29 (ii) licensed pharmacies and their employees or agents;

470.30 (iii) licensed pharmacists;

470.31 (iv) registered nurses and licensed practical nurses;

- 471.1 (v) registered medical technologists;
- 471.2 (vi) medical interns and residents;
- 471.3 (vii) licensed drug wholesalers and their employees or agents;
- 471.4 (viii) licensed hospitals;
- 471.5 (ix) bona fide hospitals in which animals are treated;
- 471.6 (x) licensed nursing homes;
- 471.7 (xi) licensed morticians;
- 471.8 (xii) syringe and needle manufacturers and their dealers and agents;
- 471.9 (xiii) persons engaged in animal husbandry;
- 471.10 (xiv) clinical laboratories and their employees;
- 471.11 (xv) persons engaged in bona fide research or education or industrial use of hypodermic
- 471.12 syringes and needles provided such persons cannot use hypodermic syringes and needles
- 471.13 for the administration of drugs to human beings unless such drugs are prescribed, dispensed,
- 471.14 and administered by a person lawfully authorized to do so; ~~and~~
- 471.15 (xvi) persons who administer drugs pursuant to an order or direction of a licensed
- 471.16 practitioner; and
- 471.17 (xvii) syringe services providers and their employees and agents;
- 471.18 (2) a person who self-administers drugs pursuant to either the prescription or the direction
- 471.19 of a practitioner, or a family member, caregiver, or other individual who is designated by
- 471.20 such person to assist the person in obtaining and using needles and syringes for the
- 471.21 administration of such drugs;
- 471.22 (3) a person who is disposing of hypodermic syringes and needles through an activity
- 471.23 or program developed under section 325F.785; ~~or~~
- 471.24 (4) a person who sells, ~~possesses~~, or handles hypodermic syringes and needles pursuant
- 471.25 to subdivision 2; or
- 471.26 (5) a participant receiving services from a syringe services provider, who accesses or
- 471.27 receives new syringes or needles from a syringe services provider or returns used syringes
- 471.28 or needles to a syringe services provider.
- 471.29 **EFFECTIVE DATE.** This section is effective August 1, 2023.

472.1 Sec. 7. Minnesota Statutes 2022, section 151.40, subdivision 2, is amended to read:

472.2 Subd. 2. **Sales of limited quantities of clean needles and syringes.** (a) A registered  
472.3 pharmacy or a licensed pharmacist may sell, without the prescription or direction of a  
472.4 practitioner, unused hypodermic needles and syringes ~~in quantities of ten or fewer,~~ provided  
472.5 the pharmacy or pharmacist complies with all of the requirements of this subdivision.

472.6 (b) At any location where hypodermic needles and syringes are kept for retail sale under  
472.7 this subdivision, the needles and syringes shall be stored in a manner that makes them  
472.8 available only to authorized personnel and not openly available to customers.

472.9 (c) A registered pharmacy or licensed pharmacist that sells hypodermic needles or  
472.10 syringes under this subdivision may give the purchaser the materials developed by the  
472.11 commissioner of health under section 325F.785.

472.12 (d) A registered pharmacy or licensed pharmacist that sells hypodermic needles or  
472.13 syringes under this subdivision must certify to the commissioner of health participation in  
472.14 an activity, including but not limited to those developed under section 325F.785, that supports  
472.15 proper disposal of used hypodermic needles or syringes.

472.16 Sec. 8. Minnesota Statutes 2022, section 151.74, subdivision 3, is amended to read:

472.17 Subd. 3. **Access to urgent-need insulin.** (a) MNsure shall develop an application form  
472.18 to be used by an individual who is in urgent need of insulin. The application must ask the  
472.19 individual to attest to the eligibility requirements described in subdivision 2. The form shall  
472.20 be accessible through MNsure's website. MNsure shall also make the form available to  
472.21 pharmacies and health care providers who prescribe or dispense insulin, hospital emergency  
472.22 departments, urgent care clinics, and community health clinics. By submitting a completed,  
472.23 signed, and dated application to a pharmacy, the individual attests that the information  
472.24 contained in the application is correct.

472.25 (b) If the individual is in urgent need of insulin, the individual may present a completed,  
472.26 signed, and dated application form to a pharmacy. The individual must also:

472.27 (1) have a valid insulin prescription; and

472.28 (2) present the pharmacist with identification indicating Minnesota residency in the form  
472.29 of a valid Minnesota identification card, driver's license or permit, individual taxpayer  
472.30 identification number, or Tribal identification card as defined in section 171.072, paragraph

472.31 (b). If the individual in urgent need of insulin is under the age of 18, the individual's parent  
472.32 or legal guardian must provide the pharmacist with proof of residency.

473.1 (c) Upon receipt of a completed and signed application, the pharmacist shall dispense  
473.2 the prescribed insulin in an amount that will provide the individual with a 30-day supply.  
473.3 The pharmacy must notify the health care practitioner who issued the prescription order no  
473.4 later than 72 hours after the insulin is dispensed.

473.5 (d) The pharmacy may submit to the manufacturer of the dispensed insulin product or  
473.6 to the manufacturer's vendor a claim for payment that is in accordance with the National  
473.7 Council for Prescription Drug Program standards for electronic claims processing, unless  
473.8 the manufacturer agrees to send to the pharmacy a replacement supply of the same insulin  
473.9 as dispensed in the amount dispensed. If the pharmacy submits an electronic claim to the  
473.10 manufacturer or the manufacturer's vendor, the manufacturer or vendor shall reimburse the  
473.11 pharmacy in an amount that covers the pharmacy's acquisition cost.

473.12 (e) The pharmacy may collect an insulin co-payment from the individual to cover the  
473.13 pharmacy's costs of processing and dispensing in an amount not to exceed \$35 for the 30-day  
473.14 supply of insulin dispensed.

473.15 (f) The pharmacy shall also provide each eligible individual with the information sheet  
473.16 described in subdivision 7 and a list of trained navigators provided by the Board of Pharmacy  
473.17 for the individual to contact if the individual is in need of accessing ongoing insulin coverage  
473.18 options, including assistance in:

473.19 (1) applying for medical assistance or MinnesotaCare;

473.20 (2) applying for a qualified health plan offered through MNsure, subject to open and  
473.21 special enrollment periods;

473.22 (3) accessing information on providers who participate in prescription drug discount  
473.23 programs, including providers who are authorized to participate in the 340B program under  
473.24 section 340b of the federal Public Health Services Act, United States Code, title 42, section  
473.25 256b; and

473.26 (4) accessing insulin manufacturers' patient assistance programs, co-payment assistance  
473.27 programs, and other foundation-based programs.

473.28 (g) The pharmacist shall retain a copy of the application form submitted by the individual  
473.29 to the pharmacy for reporting and auditing purposes.

473.30 Sec. 9. Minnesota Statutes 2022, section 151.74, subdivision 4, is amended to read:

473.31 Subd. 4. **Continuing safety net program; general.** (a) Each manufacturer shall make  
473.32 a patient assistance program available to any individual who meets the requirements of this

474.1 subdivision. Each manufacturer's patient assistance programs must meet the requirements  
474.2 of this section. Each manufacturer shall provide the Board of Pharmacy with information  
474.3 regarding the manufacturer's patient assistance program, including contact information for  
474.4 individuals to call for assistance in accessing their patient assistance program.

474.5 (b) To be eligible to participate in a manufacturer's patient assistance program, the  
474.6 individual must:

474.7 (1) be a Minnesota resident with a valid Minnesota identification card that indicates  
474.8 Minnesota residency in the form of a Minnesota identification card, driver's license or  
474.9 permit, individual taxpayer identification number, or Tribal identification card as defined  
474.10 in section 171.072, paragraph (b). If the individual is under the age of 18, the individual's  
474.11 parent or legal guardian must provide proof of residency;

474.12 (2) have a family income that is equal to or less than 400 percent of the federal poverty  
474.13 guidelines;

474.14 (3) not be enrolled in medical assistance or MinnesotaCare;

474.15 (4) not be eligible to receive health care through a federally funded program or receive  
474.16 prescription drug benefits through the Department of Veterans Affairs; and

474.17 (5) not be enrolled in prescription drug coverage through an individual or group health  
474.18 plan that limits the total amount of cost-sharing that an enrollee is required to pay for a  
474.19 30-day supply of insulin, including co-payments, deductibles, or coinsurance to \$75 or less,  
474.20 regardless of the type or amount of insulin needed.

474.21 (c) Notwithstanding the requirement in paragraph (b), clause (4), an individual who is  
474.22 enrolled in Medicare Part D is eligible for a manufacturer's patient assistance program if  
474.23 the individual has spent \$1,000 on prescription drugs in the current calendar year and meets  
474.24 the eligibility requirements in paragraph (b), clauses (1) to (3).

474.25 (d) An individual who is interested in participating in a manufacturer's patient assistance  
474.26 program may apply directly to the manufacturer; apply through the individual's health care  
474.27 practitioner, if the practitioner participates; or contact a trained navigator for assistance in  
474.28 finding a long-term insulin supply solution, including assistance in applying to a  
474.29 manufacturer's patient assistance program.

474.30 Sec. 10. Minnesota Statutes 2022, section 152.01, subdivision 18, is amended to read:

474.31 Subd. 18. **Drug paraphernalia.** (a) Except as otherwise provided in paragraph (b), "drug  
474.32 paraphernalia" means all equipment, products, and materials of any kind, except those items

475.1 used in conjunction with permitted uses of controlled substances under this chapter or the  
475.2 Uniform Controlled Substances Act, which are knowingly or intentionally used primarily  
475.3 in (1) manufacturing a controlled substance, (2) injecting, ingesting, inhaling, or otherwise  
475.4 introducing into the human body a controlled substance, or (3) testing the strength,  
475.5 ~~effectiveness, or purity of a controlled substance, or (4) enhancing the effect of a controlled~~  
475.6 substance.

475.7 (b) "Drug paraphernalia" does not include the possession, manufacture, delivery, or sale  
475.8 of: (1) ~~hypodermic needles or syringes in accordance with section 151.40, subdivision 2~~  
475.9 hypodermic syringes or needles or any instrument or implement which can be adapted for  
475.10 subcutaneous injections; or (2) products that detect the presence of fentanyl or a fentanyl  
475.11 analog in a controlled substance.

475.12 **EFFECTIVE DATE.** This section is effective August 1, 2023, and applies to crimes  
475.13 committed on or after that date.

475.14 Sec. 11. Minnesota Statutes 2022, section 152.205, is amended to read:

475.15 **152.205 LOCAL REGULATIONS.**

475.16 Sections 152.01, subdivision 18, and ~~152.092~~ 152.093 to 152.095 do not preempt  
475.17 enforcement or preclude adoption of municipal or county ordinances prohibiting or otherwise  
475.18 regulating the manufacture, delivery, possession, or advertisement of drug paraphernalia.

475.19 Sec. 12. Minnesota Statutes 2022, section 256L.03, subdivision 5, is amended to read:

475.20 Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to  
475.21 children under the age of 21 and to American Indians as defined in Code of Federal  
475.22 Regulations, title 42, section 600.5.

475.23 (b) The commissioner shall adjust co-payments, coinsurance, and deductibles for covered  
475.24 services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent.  
475.25 The cost-sharing changes described in this paragraph do not apply to eligible recipients or  
475.26 services exempt from cost-sharing under state law. The cost-sharing changes described in  
475.27 this paragraph shall not be implemented prior to January 1, 2016.

475.28 (c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements  
475.29 for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations,  
475.30 title 42, sections 600.510 and 600.520.

475.31 (d) Cost-sharing for prescription drugs and related medical supplies to treat chronic  
475.32 disease must comply with the requirements of section 62Q.481.

476.1 **EFFECTIVE DATE.** This section is effective January 1, 2024.

476.2 Sec. 13. Minnesota Statutes 2022, section 256L.03, subdivision 5, is amended to read:

476.3 Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to  
476.4 children under the age of 21 and to American Indians as defined in Code of Federal  
476.5 Regulations, title 42, section 600.5.

476.6 (b) The commissioner shall adjust co-payments, coinsurance, and deductibles for covered  
476.7 services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent.  
476.8 The cost-sharing changes described in this paragraph do not apply to eligible recipients or  
476.9 services exempt from cost-sharing under state law. The cost-sharing changes described in  
476.10 this paragraph shall not be implemented prior to January 1, 2016.

476.11 (c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements  
476.12 for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations,  
476.13 title 42, sections 600.510 and 600.520.

476.14 (d) Co-payments, coinsurance, and deductibles do not apply to additional diagnostic  
476.15 services or testing that a health care provider determines an enrollee requires after a  
476.16 mammogram, as specified under section 62A.30, subdivision 5.

476.17 **EFFECTIVE DATE.** This section is effective January 1, 2024.

476.18 Sec. 14. **REPEALER.**

476.19 Minnesota Statutes 2022, section 152.092, is repealed.

## 476.20 **ARTICLE 13**

### 476.21 **FORECAST ADJUSTMENTS**

476.22 Section 1. **DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT.**

476.23 The dollar amounts shown in the columns marked "Appropriations" are added to or, if  
476.24 shown in parentheses, are subtracted from the appropriations in Laws 2021, First Special  
476.25 Session chapter 7, article 15, and Laws 2021, First Special Session chapter 7, article 16,  
476.26 from the general fund, or any other fund named, to the commissioner of human services for  
476.27 the purposes specified in this article, to be available for the fiscal year indicated for each  
476.28 purpose. The figure "2023" used in this article means that the appropriations listed are  
476.29 available for the fiscal year ending June 30, 2023.

476.30 **APPROPRIATIONS**  
476.31 **Available for the Year**

477.1		<b><u>Ending June 30</u></b>
477.2		<b><u>2023</u></b>
477.3	<b><u>Sec. 2. COMMISSIONER OF HUMAN</u></b>	
477.4	<b><u>SERVICES</u></b>	
477.5	<b><u>Subdivision 1. Total Appropriation</u></b>	<b><u>\$ (1,453,441,000)</u></b>
477.6	<u>Appropriations by Fund</u>	
477.7	<u>2023</u>	
477.8	<u>General</u>	<u>(1,228,684,000)</u>
477.9	<u>Health Care Access</u>	<u>(203,530,000)</u>
477.10	<u>Federal TANF</u>	<u>(21,227,000)</u>
477.11	<b><u>Subd. 2. Forecasted Programs</u></b>	
477.12	<b><u>(a) Minnesota Family</u></b>	
477.13	<b><u>Investment Program</u></b>	
477.14	<b><u>(MFIP)/Diversionary Work</u></b>	
477.15	<b><u>Program (DWP)</u></b>	
477.16	<u>Appropriations by Fund</u>	
477.17	<u>2023</u>	
477.18	<u>General</u>	<u>(99,000)</u>
477.19	<u>Federal TANF</u>	<u>(21,227,000)</u>
477.20	<b><u>(b) MFIP Child Care Assistance</u></b>	<b><u>(36,957,000)</u></b>
477.21	<b><u>(c) General Assistance</u></b>	<b><u>(1,632,000)</u></b>
477.22	<b><u>(d) Minnesota Supplemental Aid</u></b>	<b><u>783,000</u></b>
477.23	<b><u>(e) Housing Support</u></b>	<b><u>180,000</u></b>
477.24	<b><u>(f) Northstar Care for Children</u></b>	<b><u>(18,038,000)</u></b>
477.25	<b><u>(g) MinnesotaCare</u></b>	<b><u>(203,530,000)</u></b>
477.26	<u>This appropriation is from the health care</u>	
477.27	<u>access fund.</u>	
477.28	<b><u>(h) Medical Assistance</u></b>	
477.29	<u>Appropriations by Fund</u>	
477.30	<u>2023</u>	
477.31	<u>General</u>	<u>(1,172,921,000)</u>
477.32	<u>Health Care Access</u>	<u>0</u>
477.33	<b><u>(i) Behavioral Health Fund</u></b>	<b><u>(6,404,000)</u></b>



479.1 qualified nonfederal expenditures are made  
479.2 each year to meet the state's maintenance of  
479.3 effort requirements of the TANF block grant  
479.4 specified under Code of Federal Regulations,  
479.5 title 45, section 263.1. In order to meet these  
479.6 basic TANF maintenance of effort  
479.7 requirements, the commissioner may report  
479.8 as TANF maintenance of effort expenditures  
479.9 only nonfederal money expended for allowable  
479.10 activities listed in the following clauses:

479.11 (1) MFIP cash, diversionary work program,  
479.12 and food assistance benefits under Minnesota  
479.13 Statutes, chapter 256J;

479.14 (2) the child care assistance programs under  
479.15 Minnesota Statutes, sections 119B.03 and  
479.16 119B.05, and county child care administrative  
479.17 costs under Minnesota Statutes, section  
479.18 119B.15;

479.19 (3) state and county MFIP administrative costs  
479.20 under Minnesota Statutes, chapters 256J and  
479.21 256K;

479.22 (4) state, county, and Tribal MFIP  
479.23 employment services under Minnesota  
479.24 Statutes, chapters 256J and 256K;

479.25 (5) expenditures made on behalf of legal  
479.26 noncitizen MFIP recipients who qualify for  
479.27 the MinnesotaCare program under Minnesota  
479.28 Statutes, chapter 256L;

479.29 (6) qualifying working family credit  
479.30 expenditures under Minnesota Statutes, section  
479.31 290.0671;

479.32 (7) qualifying Minnesota education credit  
479.33 expenditures under Minnesota Statutes, section  
479.34 290.0674; and

480.1 (8) qualifying Head Start expenditures under  
480.2 Minnesota Statutes, section 119A.50.

480.3 **(b) Nonfederal Expenditures; Reporting.**  
480.4 For the activities listed in paragraph (a),  
480.5 clauses (2) to (8), the commissioner may  
480.6 report only expenditures that are excluded  
480.7 from the definition of assistance under Code  
480.8 of Federal Regulations, title 45, section  
480.9 260.31.

480.10 **(c) Limitations; Exceptions. The**  
480.11 commissioner must not claim an amount of  
480.12 TANF maintenance of effort in excess of the  
480.13 75 percent standard in Code of Federal  
480.14 Regulations, title 45, section 263.1(a)(2),  
480.15 except:

480.16 (1) to the extent necessary to meet the 80  
480.17 percent standard under Code of Federal  
480.18 Regulations, title 45, section 263.1(a)(1), if it  
480.19 is determined by the commissioner that the  
480.20 state will not meet the TANF work  
480.21 participation target rate for the current year;

480.22 (2) to provide any additional amounts under  
480.23 Code of Federal Regulations, title 45, section  
480.24 264.5, that relate to replacement of TANF  
480.25 funds due to the operation of TANF penalties;  
480.26 and

480.27 (3) to provide any additional amounts that may  
480.28 contribute to avoiding or reducing TANF work  
480.29 participation penalties through the operation  
480.30 of the excess maintenance of effort provisions  
480.31 of Code of Federal Regulations, title 45,  
480.32 section 261.43(a)(2).

480.33 **(d) Supplemental Expenditures. For the**  
480.34 purposes of paragraph (c), the commissioner

481.1 may supplement the maintenance of effort  
481.2 claim with working family credit expenditures  
481.3 or other qualified expenditures to the extent  
481.4 such expenditures are otherwise available after  
481.5 considering the expenditures allowed in this  
481.6 subdivision.

481.7 **(e) Reduction of Appropriations; Exception.**  
481.8 The requirement in Minnesota Statutes, section  
481.9 256.011, subdivision 3, that federal grants or  
481.10 aids secured or obtained under that subdivision  
481.11 be used to reduce any direct appropriations  
481.12 provided by law does not apply if the grants  
481.13 or aids are federal TANF funds.

481.14 **(f) IT Appropriations Generally. This**  
481.15 appropriation includes funds for information  
481.16 technology projects, services, and support.  
481.17 Notwithstanding Minnesota Statutes, section  
481.18 16E.0466, funding for information technology  
481.19 project costs must be incorporated into the  
481.20 service level agreement and paid to the  
481.21 Minnesota IT Services by the Department of  
481.22 Human Services under the rates and  
481.23 mechanism specified in that agreement.

481.24 **(g) Receipts for Systems Project.**  
481.25 Appropriations and federal receipts for  
481.26 information technology systems projects for  
481.27 MAXIS, PRISM, MMIS, ISDS, METS, and  
481.28 SSIS must be deposited in the state systems  
481.29 account authorized in Minnesota Statutes,  
481.30 section 256.014. Money appropriated for  
481.31 information technology projects approved by  
481.32 the commissioner of the Minnesota IT  
481.33 Services funded by the legislature and  
481.34 approved by the commissioner of management  
481.35 and budget may be transferred from one

482.1 project to another and from development to  
 482.2 operations as the commissioner of human  
 482.3 services considers necessary. Any unexpended  
 482.4 balance in the appropriation for these projects  
 482.5 does not cancel and is available for ongoing  
 482.6 development and operations.

482.7 **(h) Federal SNAP Education and Training**  
 482.8 **Grants.** Federal funds available during fiscal  
 482.9 years 2024 and 2025 for Supplemental  
 482.10 Nutrition Assistance Program Education and  
 482.11 Training and SNAP Quality Control  
 482.12 Performance Bonus grants are appropriated  
 482.13 to the commissioner of human services for the  
 482.14 purposes allowable under the terms of the  
 482.15 federal award. This paragraph is effective the  
 482.16 day following final enactment.

482.17 **Subd. 3. Central Office; Operations**

482.18	<u>Appropriations by Fund</u>	
482.19	<u>General</u>	<u>267,092,000</u> <u>241,948,000</u>
482.20	<u>State Government</u>	
482.21	<u>Special Revenue</u>	<u>4,721,000</u> <u>5,169,000</u>
482.22	<u>Health Care Access</u>	<u>9,347,000</u> <u>11,244,000</u>
482.23	<u>Federal TANF</u>	<u>1,090,000</u> <u>1,194,000</u>

482.24 **(a) Administrative Recovery; Set-Aside.** The  
 482.25 commissioner may invoice local entities  
 482.26 through the SWIFT accounting system as an  
 482.27 alternative means to recover the actual cost of  
 482.28 administering the following provisions:  
 482.29 (1) the statewide data management system  
 482.30 authorized in Minnesota Statutes, section  
 482.31 125A.744, subdivision 3;  
 482.32 (2) repayment of the special revenue  
 482.33 maximization account as provided under  
 482.34 Minnesota Statutes, section 245.495,  
 482.35 paragraph (b);

- 483.1 (3) repayment of the special revenue  
 483.2 maximization account as provided under  
 483.3 Minnesota Statutes, section 256B.0625,  
 483.4 subdivision 20, paragraph (k);
- 483.5 (4) targeted case management under  
 483.6 Minnesota Statutes, section 256B.0924,  
 483.7 subdivision 6, paragraph (g);
- 483.8 (5) residential services for children with severe  
 483.9 emotional disturbance under Minnesota  
 483.10 Statutes, section 256B.0945, subdivision 4,  
 483.11 paragraph (d); and
- 483.12 (6) repayment of the special revenue  
 483.13 maximization account as provided under  
 483.14 Minnesota Statutes, section 256F.10,  
 483.15 subdivision 6, paragraph (b).

- 483.16 (b) Base Level Adjustment. The general fund  
 483.17 base is \$212,294,000 in fiscal year 2026 and  
 483.18 \$230,052,000 in fiscal year 2027. The state  
 483.19 government special revenue base is \$4,765,000  
 483.20 in fiscal year 2026 and \$4,765,000 in fiscal  
 483.21 year 2027.

483.22 Subd. 4. Central Office; Children and Families

483.23	<u>Appropriations by Fund</u>		
483.24	<u>General</u>	<u>18,791,000</u>	<u>18,797,000</u>
483.25	<u>Federal TANF</u>	<u>2,582,000</u>	<u>2,582,000</u>

483.26 Subd. 5. Central Office; Health Care

483.27	<u>Appropriations by Fund</u>		
483.28	<u>General</u>	<u>33,442,000</u>	<u>33,650,000</u>
483.29	<u>Health Care Access</u>	<u>28,168,000</u>	<u>28,168,000</u>

- 483.30 (a) Dental Home Pilot Project. \$312,000 in  
 483.31 fiscal year 2024 and \$347,000 in fiscal year  
 483.32 2025 are from the general fund to establish  
 483.33 and evaluate the dental home pilot project.

484.1 The general fund base for this appropriation  
 484.2 is \$347,000 in fiscal year 2026, \$347,000 in  
 484.3 fiscal year 2027, \$347,000 in fiscal year 2028,  
 484.4 and \$0 in fiscal year 2029.

484.5 (b) Base Level Adjustment. The general fund  
 484.6 base is \$47,017,000 in fiscal year 2026 and  
 484.7 \$61,778,000 in fiscal year 2027.

484.8 Subd. 6. Central Office; Continuing Care for  
 484.9 Older Adults

484.10	<u>Appropriations by Fund</u>		
484.11	<u>General</u>	<u>38,726,000</u>	<u>34,688,000</u>
484.12	<u>State Government</u>		
484.13	<u>Special Revenue</u>	<u>125,000</u>	<u>125,000</u>

484.14	<u>Subd. 7. Central Office; Behavioral Health,</u>		
484.15	<u>Housing, and Deaf and Hard of Hearing</u>		
484.16	<u>Services</u>	<u>26,963,000</u>	<u>26,305,000</u>

484.17 (a) Evaluation of Outcomes; PATH Grants.  
 484.18 \$150,000 in fiscal year 2025 is for evaluating  
 484.19 outcomes for the additional grant funding for  
 484.20 the expansion of base funding for the PATH  
 484.21 grants. This is a onetime appropriation.

484.22 (b) Online Locator. \$1,720,000 in fiscal year  
 484.23 2024 and \$1,720,000 in fiscal year 2025 are  
 484.24 for an online behavioral health program  
 484.25 locator with continued expansion of the  
 484.26 provider database allowing people to research  
 484.27 and access mental health and substance use  
 484.28 disorder treatment options.

484.29 (c) Base Level Adjustment. The general fund  
 484.30 base is \$24,421,000 in fiscal year 2026 and  
 484.31 \$24,339,000 in fiscal year 2027.

484.32	<u>Subd. 8. Forecasted Programs; MFIP/DWP</u>	<u>77,000</u>	<u>108,000</u>
484.33	<u>Subd. 9. Forecasted Programs; General</u>		
484.34	<u>Assistance</u>	<u>52,018,000</u>	<u>74,455,000</u>

485.1 **Emergency General Assistance.** The amount  
 485.2 appropriated for emergency general assistance  
 485.3 is limited to no more than \$6,729,812 in fiscal  
 485.4 year 2024 and \$6,729,812 in fiscal year 2025.  
 485.5 Funds to counties shall be allocated by the  
 485.6 commissioner using the allocation method  
 485.7 under Minnesota Statutes, section 256D.06.

485.8	<u><b>Subd. 10. Forecasted Programs; Minnesota</b></u>		
485.9	<u><b>Supplemental Aid</b></u>	<u>58,320,000</u>	<u>59,865,000</u>

485.10	<u><b>Subd. 11. Forecasted Programs; Housing</b></u>		
485.11	<u><b>Support</b></u>	<u>211,692,000</u>	<u>224,225,000</u>

485.12	<u><b>Subd. 12. Forecasted Programs; MinnesotaCare</b></u>		
		<u>89,306,000</u>	<u>60,533,000</u>

485.13 These appropriations are from the health care  
 485.14 access fund.

485.15 **Subd. 13. Forecasted Programs; Medical**  
 485.16 **Assistance**

485.17	<u>Appropriations by Fund</u>		
485.18	<u>General</u>	<u>1,091,518,000</u>	<u>805,855,000</u>
485.19	<u>Health Care Access</u>	<u>869,524,000</u>	<u>1,214,701,000</u>

485.20 **Base Level Adjustment.** The health care  
 485.21 access fund base is \$570,233,000 in fiscal year  
 485.22 2026, \$1,147,261,000 in fiscal year 2027, and  
 485.23 \$612,099,000 in fiscal year 2028.

485.24	<u><b>Subd. 14. Forecasted Programs; Alternative</b></u>		
485.25	<u><b>Care</b></u>	<u>79,000</u>	<u>230,000</u>

485.26	<u><b>Subd. 15. Forecasted Programs; Behavioral</b></u>		
485.27	<u><b>Health Fund</b></u>	<u>847,000</u>	<u>1,766,000</u>

485.28 **Subd. 16. Grant Programs; Health Care Grants**

485.29	<u>Appropriations by Fund</u>		
485.30	<u>General</u>	<u>7,311,000</u>	<u>7,311,000</u>
485.31	<u>Health Care Access</u>	<u>3,465,000</u>	<u>3,465,000</u>

485.32 **(a) Indian Health Board.** \$2,500,000 in fiscal  
 485.33 year 2024 and \$2,500,000 in fiscal year 2025  
 485.34 are from the general fund for funding to the  
 485.35 Indian Health Board of Minneapolis to support

486.1 continued access to health care coverage  
 486.2 through Minnesota health care programs,  
 486.3 improve access to quality care, and increase  
 486.4 vaccination rates among urban American  
 486.5 Indians. The general fund base for this  
 486.6 appropriation is \$2,500,000 in fiscal year 2026  
 486.7 and \$0 in fiscal year 2027.

486.8 (b) Base Level Adjustment. The general fund  
 486.9 base is \$7,311,000 in fiscal year 2026 and  
 486.10 \$4,811,000 in fiscal year 2027.

486.11 <u>Subd. 17. Grant Programs; Disabilities Grants</u>	<u>500,000</u>	<u>1,000,000</u>
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486.12 (a) Transition to Community Initiative.  
 486.13 \$500,000 in fiscal year 2024 and \$1,000,000  
 486.14 in fiscal year 2025 are for the transition to  
 486.15 community grant initiative grant funding under  
 486.16 the Laws 2021, First Special Session chapter  
 486.17 7, article 17, section 6.

486.18 (b) Base Level Adjustment. The general fund  
 486.19 base is \$1,000,000 in fiscal year 2026, and  
 486.20 \$100,00 in fiscal year 2027.

486.21 <u>Subd. 18. Grant Programs; Housing Support</u>		
486.22 <u>Grants</u>	<u>19,464,000</u>	<u>11,464,000</u>

486.23 Heading Home Corps. \$1,100,000 in fiscal  
 486.24 year 2024 and \$1,100,000 in fiscal year 2025  
 486.25 are for the AmeriCorps Heading Home Corps  
 486.26 program.

486.27 <u>Subd. 19. Grant Programs; Adult Mental Health</u>		
486.28 <u>Grants</u>	<u>127,912,000</u>	<u>137,925,000</u>

486.29 (a) White Earth Nation; Adult Mental  
 486.30 Health Initiative. \$300,000 in fiscal year  
 486.31 2024 and \$300,000 in fiscal year 2025 are for  
 486.32 adult mental health initiative grants to the  
 486.33 White Earth Nation. This is a onetime  
 486.34 appropriation.

487.1 **(b) Transition to Community Initiative.**  
 487.2 \$750,000 in fiscal year 2024 and \$750,000 in  
 487.3 fiscal year 2025 are for the transition to  
 487.4 community grant initiative grant funding under  
 487.5 Laws 2021, First Special Session chapter 7,  
 487.6 article 17, section 6.

487.7 **(c) Mobile Crisis Grants.** \$4,000,000 in fiscal  
 487.8 year 2024 and \$8,000,000 in fiscal year 2025  
 487.9 are for the mobile crisis grants under the Laws  
 487.10 2021, First Special Session chapter 7, article  
 487.11 17, section 11. This is a onetime appropriation.

487.12 **(d) Mobile Crisis Funds to Tribal Nations.**  
 487.13 \$1,000,000 in fiscal year 2024 and \$1,000,000  
 487.14 in fiscal year 2025 are for mobile crisis funds  
 487.15 to Tribal Nations. This is a onetime  
 487.16 appropriation.

487.17 **(e) Base Level Adjustment.** The general fund  
 487.18 base is \$127,297,000 in fiscal year 2026 and  
 487.19 \$127,297,000 in fiscal year 2027.

487.20 **Subd. 20. Grant Programs; Child Mental Health**  
 487.21 **Grants**

50,128,000

43,426,000

487.22 **(a) School-Linked Behavioral Health**  
 487.23 **Services.** \$11,248,000 in fiscal year 2024 and  
 487.24 \$8,400,000 in fiscal year 2025 are for  
 487.25 school-linked behavioral health services and  
 487.26 for school-linked behavioral health services  
 487.27 in intermediate school districts. The base for  
 487.28 this appropriation is \$2,500,000 in fiscal year  
 487.29 2026 and \$2,500,000 in fiscal year 2027.

487.30 **(b) Psychiatric Residential Treatment**  
 487.31 **Facility Specialization Grants.** \$1,050,000  
 487.32 in fiscal year 2024 and \$1,050,000 in fiscal  
 487.33 year 2025 are for psychiatric residential  
 487.34 treatment facilities specialization grants for

488.1 staffing costs to treat and support behavioral  
 488.2 health conditions and support children and  
 488.3 families.

488.4 (c) Base Level Adjustment. The general fund  
 488.5 base is \$37,526,000 in fiscal year 2026 and  
 488.6 \$37,526,000 in fiscal year 2027.

488.7 Subd. 21. Grant Programs; Chemical  
 488.8 Dependency Treatment Support Grants

488.9 Appropriations by Fund

488.10 General 1,350,000 1,350,000

488.11 Subd. 22. Technical Activities 71,493,000 71,493,000

488.12 This appropriation is from the federal TANF  
 488.13 fund.

488.14 Sec. 3. COMMISSIONER OF HEALTH

488.15 Subdivision 1. Total Appropriation \$ 473,547,000 \$ 435,321,000

488.16 Appropriations by Fund

488.17 2024 2025

488.18 General 327,115,000 278,748,000

488.19 State Government  
 488.20 Special Revenue 83,373,000 85,902,000

488.21 Health Care Access 38,857,000 41,557,000

488.22 Federal TANF 11,713,000 11,713,000

488.23 The amounts that may be spent for each  
 488.24 purpose are specified in the following  
 488.25 subdivisions.

488.26 Subd. 2. Health Improvement

488.27 Appropriations by Fund

488.28 General 272,015,000 272,758,000

488.29 State Government  
 488.30 Special Revenue 12,392,000 12,682,000

488.31 Health Care Access 38,857,000 41,557,000

488.32 Federal TANF 11,713,000 11,713,000

488.33 (a) Telehealth; Payment Parity. Of the  
 488.34 amount appropriated in Laws 2021, First

489.1 Special Session chapter 7, article 16, section  
489.2 3, subdivision 2, \$1,200,000 from the general  
489.3 fund in fiscal year 2023 is for the studies of  
489.4 telehealth expansion and payment parity and  
489.5 is available until June 30, 2024.

489.6 **(b) Adolescent Mental Health Promotion.**  
489.7 \$2,790,000 in fiscal year 2024 and \$2,790,000  
489.8 in fiscal year 2025 are from the general fund  
489.9 for adolescent mental health promotion. Of  
489.10 this appropriation each year, \$2,250,000 is for  
489.11 grants and \$540,000 is for administration. This  
489.12 is a onetime appropriation.

489.13 **(c) Advancing Equity Through Capacity**  
489.14 **Building and Resource Allocation.**  
489.15 \$1,986,000 in fiscal year 2024 and \$1,986,000  
489.16 in fiscal year 2025 are from the general fund  
489.17 to advance equity in procurement and  
489.18 grantmaking. Of this appropriation each year,  
489.19 \$1,000,000 is for grants and \$986,000 is for  
489.20 administration. This is a onetime  
489.21 appropriation.

489.22 **(d) Community Solutions for Healthy Child**  
489.23 **Development Grants.** \$4,980,000 in fiscal  
489.24 year 2024 and \$5,055,000 in fiscal year 2025  
489.25 are from the general fund to improve child  
489.26 development outcomes and well-being of  
489.27 children of color and American Indian children  
489.28 and their families, under Minnesota Statutes,  
489.29 section 145.9257. Of this appropriation in  
489.30 fiscal year 2024, \$4,000,000 is for grants and  
489.31 \$980,000 is for administration and in fiscal  
489.32 year 2025, \$4,000,000 is for grants and  
489.33 \$1,055,000 is for administration.

489.34 **(e) Comprehensive Overdose and Morbidity**  
489.35 **Prevention Act.** \$8,164,000 in fiscal year

490.1 2024 and \$8,164,000 in fiscal year 2025 are  
490.2 from the general fund for comprehensive  
490.3 overdose and morbidity prevention strategies  
490.4 under Minnesota Statutes, section 144.0528.  
490.5 Of this appropriation each year, \$6,250,000  
490.6 is for grants and \$1,644,000 is for  
490.7 administration.

490.8 **(f) Emergency Preparedness and Response.**  
490.9 \$12,400,000 in fiscal year 2024 and  
490.10 \$12,400,000 in fiscal year 2025 are from the  
490.11 general fund for public health emergency  
490.12 preparedness and response, the sustainability  
490.13 of the strategic stockpile, and COVID-19  
490.14 pandemic response transition. Of this  
490.15 appropriation each year, \$8,400,000 is for  
490.16 grants and \$4,000,000 is for administration.  
490.17 The general fund base for this appropriation  
490.18 is \$11,400,000 in fiscal year 2026, of which  
490.19 \$8,400,000 is for grants and \$3,000,000 is for  
490.20 administration, and \$11,400,000 in fiscal year  
490.21 2027, of which \$8,400,000 is for grants and  
490.22 \$3,000,000 is for administration.

490.23 **(g) Healthy Beginnings, Healthy Families.**  
490.24 \$12,052,000 in fiscal year 2024 and  
490.25 \$11,853,000 in fiscal year 2025 are from the  
490.26 general fund for a comprehensive approach to  
490.27 ensure healthy outcomes for children and  
490.28 families. Of this appropriation in fiscal year  
490.29 2024, \$8,750,000 is for grants and \$3,302,000  
490.30 is for administration and in fiscal year 2025,  
490.31 \$8,750,000 is for grants and \$3,103,000 is for  
490.32 administration. This is a onetime  
490.33 appropriation.

490.34 **(h) No Surprises Act Enforcement.**  
490.35 \$1,210,000 in fiscal year 2024 and \$1,090,000

491.1 in fiscal year 2025 are from the general fund  
491.2 for implementation of the federal No Surprises  
491.3 Act portion of the Consolidated  
491.4 Appropriations Act, 2021, under Minnesota  
491.5 Statutes, section 62Q.021, and assessment of  
491.6 feasibility of a statewide provider directory.  
491.7 The general fund base for this appropriation  
491.8 is \$855,000 in fiscal year 2026 and \$855,000  
491.9 in fiscal year 2027.

491.10 (i) **African American Health.** \$2,182,000 in  
491.11 fiscal year 2024 and \$2,182,000 in fiscal year  
491.12 2025 are from the general fund to establish an  
491.13 Office of African American Health at the  
491.14 Minnesota Department of Health under  
491.15 Minnesota Statutes, section 144.0755, and for  
491.16 grants under Minnesota Statutes, section  
491.17 144.0756. Of this appropriation each year,  
491.18 \$1,000,000 is for grants and \$1,182,000 is for  
491.19 administration. The general fund base for this  
491.20 appropriation is \$2,182,00 in fiscal year 2026,  
491.21 of which \$1,000,000 is for grants and  
491.22 \$1,182,000 is for administration, and  
491.23 \$2,117,000 in fiscal year 2027, of which  
491.24 \$1,000,000 is for grants and \$1,117,000 is for  
491.25 administration.

491.26 (j) **American Indian Health.** \$2,089,000 in  
491.27 fiscal year 2024 and \$2,089,000 in fiscal year  
491.28 2025 are from the general fund for the Office  
491.29 of American Indian Health at the Minnesota  
491.30 Department of Health under Minnesota  
491.31 Statutes, section 144.0757. Of this  
491.32 appropriation each year, \$1,000,000 is for  
491.33 grants and \$1,089,000 is for administration.

491.34 (k) **Public Health System Transformation.**  
491.35 \$17,120,000 in fiscal year 2024 and

492.1 \$17,120,000 in fiscal year 2025 are from the  
492.2 general fund for public health system  
492.3 transformation. Of this appropriation each  
492.4 year:

492.5 (1) \$15,000,000 is for grants to community  
492.6 health boards under Minnesota Statutes,  
492.7 section 145A.131, subdivision 1, paragraph  
492.8 (f);

492.9 (2) \$750,000 is for grants to Tribal  
492.10 governments under Minnesota Statutes, section  
492.11 145A.14, subdivision 2b;

492.12 (3) \$500,000 is for a public health AmeriCorps  
492.13 program grant under Minnesota Statutes,  
492.14 section 144.0759; and

492.15 (4) \$870,000 is for oversight and  
492.16 administration of activities under this  
492.17 paragraph.

492.18 The base for this appropriation is \$8,000,000  
492.19 in fiscal year 2026 and \$8,000,000 in fiscal  
492.20 year 2027.

492.21 (l) **Health Care Workforce.** \$6,120,000 in  
492.22 fiscal year 2024 and \$7,400,000 in fiscal year  
492.23 2025 are from the general fund to revitalize  
492.24 the Minnesota health care workforce. The  
492.25 general fund base for this appropriation is  
492.26 \$6,850,000 in fiscal year 2026 and \$7,100,000  
492.27 in fiscal year 2027. Of this appropriation:

492.28 (1) \$750,000 in fiscal year 2024 and  
492.29 \$2,000,000 in fiscal year 2025 are for rural  
492.30 training tracks and rural clinicals grants under  
492.31 Minnesota Statutes, section 144.1508;

492.32 (2) \$220,000 in fiscal year 2024 and \$200,000  
492.33 in fiscal year 2025 are for immigrant

493.1 international medical graduate training grants  
493.2 under Minnesota Statutes, section 144.1911;  
493.3 (3) \$3,250,000 in fiscal year 2024 and  
493.4 \$3,300,000 in fiscal year 2025 are for  
493.5 site-based clinical training grants under  
493.6 Minnesota Statutes, section 144.1505. The  
493.7 base for this appropriation is \$3,000,000 in  
493.8 fiscal year 2026 and \$3,000,000 in fiscal year  
493.9 2027;  
493.10 (4) \$500,000 in fiscal year 2024 and \$500,000  
493.11 in fiscal year 2025 are for mental health for  
493.12 health care professionals grants. These  
493.13 appropriations are available until June 30,  
493.14 2027, and are onetime appropriations;  
493.15 (5) \$400,000 in fiscal year 2024 and \$400,000  
493.16 in fiscal year 2025 are for primary care  
493.17 employee recruitment education loan  
493.18 forgiveness under Minnesota Statutes, section  
493.19 144.1504;  
493.20 (6) \$750,000 in fiscal year 2024 and \$750,000  
493.21 in fiscal year 2025 are for administration of  
493.22 the grant programs and loan forgiveness  
493.23 programs under this paragraph; and  
493.24 (7) \$250,000 in fiscal year 2024 and \$250,000  
493.25 in fiscal year 2025 are for workforce research  
493.26 and data on shortages, maldistribution of  
493.27 health care providers in Minnesota, and  
493.28 determinants of practicing in rural areas.  
493.29 (m) **School Health.** \$1,432,000 in fiscal year  
493.30 2024 and \$1,932,000 in fiscal year 2025 are  
493.31 from the general fund for school-based health  
493.32 centers under Minnesota Statutes, section  
493.33 145.903. Of this appropriation each year,  
493.34 \$800,000 is for grants and \$632,000 is for

494.1 administration. The general fund base for this  
494.2 appropriation is \$2,983,000 in fiscal year  
494.3 2026, of which \$2,300,000 is for grants and  
494.4 \$683,000 is for administration, and \$2,983,000  
494.5 in fiscal year 2027, of which \$2,300,000 is for  
494.6 grants and \$683,000 is for administration.

494.7 (n) **Long COVID.** \$3,146,000 in fiscal year  
494.8 2024 and \$3,146,000 in fiscal year 2025 are  
494.9 from the general fund to address long COVID  
494.10 and post-COVID conditions. Of this  
494.11 appropriation each year, \$900,000 is for grants  
494.12 and \$2,246,000 is for administration. This is  
494.13 a onetime appropriation.

494.14 (o) **Home Visiting for Priority Populations.**  
494.15 \$2,500,000 in fiscal year 2024 and \$2,500,000  
494.16 in fiscal year 2025 are from the general fund  
494.17 to expand home visiting for priority  
494.18 populations under Minnesota Statutes, section  
494.19 145.875. Of this appropriation each year,  
494.20 \$2,250,000 is for grants and \$250,000 is for  
494.21 administration.

494.22 (p) **Clinical Dental Education Innovation**  
494.23 **Grants.** \$1,182,000 in fiscal year 2024 and  
494.24 \$1,182,000 in fiscal year 2025 are from the  
494.25 general fund for clinical dental education  
494.26 innovation grants under Minnesota Statutes,  
494.27 section 144.1913. Of this appropriation each  
494.28 year, \$1,122,000 is for grants and \$60,000 is  
494.29 for administration.

494.30 (q) **Medical Education and Research Costs.**  
494.31 \$300,000 in fiscal year 2024 and \$300,000 in  
494.32 fiscal year 2025 are from the general fund for  
494.33 administration of the medical education and  
494.34 research costs program under Minnesota  
494.35 Statutes, section 62J.692.

495.1 **(r) Health Care Affordability Commission**  
495.2 **and Advisory Council.** \$4,131,000 in fiscal  
495.3 year 2024 and \$4,773,000 in fiscal year 2025  
495.4 are from the general fund for the costs of the  
495.5 Health Care Affordability Commission and  
495.6 the Health Care Affordability Advisory  
495.7 Council, including the costs to the  
495.8 commissioner to provide technical and  
495.9 administrative support. The general fund base  
495.10 for this appropriation is \$4,787,000 in fiscal  
495.11 year 2026 and \$4,784,000 in fiscal year 2027.

495.12 **(s) Economic Analysis; Analytic Tool.**  
495.13 \$4,420,000 in fiscal year 2024 and \$580,000  
495.14 in fiscal year 2025 are from the general fund  
495.15 to contract for and conduct an economic  
495.16 analysis of the benefits and costs of universal  
495.17 health care system reform models and to  
495.18 develop a related analytic tool. The general  
495.19 fund base for this appropriation is \$580,000  
495.20 in fiscal year 2026 and \$0 in fiscal year 2027.  
495.21 This appropriation is available until June 30,  
495.22 2027.

495.23 **(t) Keeping Nurses at the Bedside Act.**  
495.24 \$11,553,000 in fiscal year 2024 and  
495.25 \$11,558,000 in fiscal year 2025 are from the  
495.26 general fund for the Keeping Nurses at the  
495.27 Bedside Act. Of these appropriations:

495.28 (1) \$5,000,000 in fiscal year 2024 and  
495.29 \$5,000,000 in fiscal year 2025 are for mental  
495.30 health grants for health care professionals  
495.31 under Laws 2022, chapter 99, article 1, section  
495.32 46;

495.33 (2) notwithstanding the priorities and  
495.34 distribution requirements under Minnesota  
495.35 Statutes, section 144.1501, \$5,050,000 in

496.1 fiscal year 2024 and \$5,050,000 in fiscal year  
496.2 2025 are for the health professional education  
496.3 loan forgiveness program under Minnesota  
496.4 Statutes, section 144.1501, of which:  
496.5 (i) \$5,000,000 in fiscal year 2024 and  
496.6 \$5,000,000 in fiscal year 2025 are for  
496.7 distribution to eligible nurses who have agreed  
496.8 to work as hospital nurses in accordance with  
496.9 Minnesota Statutes, section 144.1501,  
496.10 subdivision 2, paragraph (a), clause (7); and  
496.11 (ii) \$50,000 in fiscal year 2024 and \$50,000  
496.12 in fiscal year 2025 are for distribution to  
496.13 eligible nurses who have agreed to teach in  
496.14 accordance with Minnesota Statutes, section  
496.15 144.1501, subdivision 2, paragraph (a), clause  
496.16 (3); and  
496.17 (4) \$1,503,000 in fiscal year 2024 and  
496.18 \$1,508,000 in fiscal year 2025 are for the  
496.19 commissioner of health to administer  
496.20 Minnesota Statutes, section 144.7057; to  
496.21 perform the grading duties described in  
496.22 Minnesota Statutes, section 144.7058; to  
496.23 continue the prevention of violence in health  
496.24 care programs and to create violence  
496.25 prevention resources for hospitals and other  
496.26 health care providers to use to train their staff  
496.27 on violence prevention; for work to identify  
496.28 potential links between adverse events and  
496.29 understaffing; and for a report on the current  
496.30 status of the state's nursing workforce  
496.31 employed by hospitals.  
496.32 **(u) Supporting Healthy Development of**  
496.33 **Babies During Pregnancy and Postpartum.**  
496.34 \$260,000 in fiscal year 2024 is from the  
496.35 general fund for a grant to the Amherst H.

497.1 Wilder Foundation for the African American  
497.2 Babies Coalition initiative for  
497.3 community-driven training and education on  
497.4 best practices to support healthy development  
497.5 of babies during pregnancy and postpartum.  
497.6 The grant must be used to build capacity in,  
497.7 train, educate, or improve practices among  
497.8 individuals, from youth to elders, serving  
497.9 families with members who are Black,  
497.10 Indigenous, or People of Color during  
497.11 pregnancy and postpartum. This appropriation  
497.12 is available until June 30, 2025.

497.13 **(v) Critical Access Dental Infrastructure**  
497.14 **Program. \$20,000,000 in fiscal year 2024 is**  
497.15 **from the general fund for the critical access**  
497.16 **dental infrastructure program. This**  
497.17 **appropriation is available until June 30, 2026.**

497.18 **(w) Workplace Safety Grants Program.**  
497.19 **\$10,000,000 in fiscal year 2024 is from the**  
497.20 **general fund for the workplace safety grants**  
497.21 **program for health care entities and human**  
497.22 **services providers. This appropriation is**  
497.23 **available until June 30, 2025.**

497.24 **(x) Analyses and Reports; Health Care**  
497.25 **Transactions. \$2,000,000 in fiscal year 2024**  
497.26 **is from the general fund to conduct analyses**  
497.27 **of the impacts of health care transactions on**  
497.28 **health care cost, quality, and competition, and**  
497.29 **to issue public reports on health care**  
497.30 **transactions in Minnesota and their impacts.**  
497.31 **This appropriation is available until June 30,**  
497.32 **2025.**

497.33 **(y) Provider Orders for Life-sustaining**  
497.34 **Treatment Registry. \$530,000 in fiscal year**  
497.35 **2024 and \$1,655,000 in fiscal year 2025 are**

498.1 from the general fund to study and implement  
498.2 a statewide registry for provider orders for  
498.3 life-sustaining treatment. The general fund  
498.4 base for this appropriation is \$658,000 in fiscal  
498.5 year 2026 and \$658,000 in fiscal year 2027.

498.6 **(z) Emmett Louis Till Victims Recovery**  
498.7 **Program.** \$500,000 in fiscal year 2024 is from  
498.8 the general fund for the Emmett Louis Till  
498.9 victims recovery program. This appropriation  
498.10 is available until June 30, 2025.

498.11 **(aa) Task Force on Pregnancy Health and**  
498.12 **Substance Use Disorders.** \$100,000 in fiscal  
498.13 year 2024 is from the general fund for the Task  
498.14 Force on Pregnancy Health and Substance Use  
498.15 Disorders. This appropriation is available until  
498.16 December 1, 2024.

498.17 **(bb) Labor Trafficking Services Programs.**  
498.18 \$546,000 in fiscal year 2024 and \$546,000 in  
498.19 fiscal year 2025 are from the general fund for  
498.20 grants for comprehensive, trauma-informed,  
498.21 and culturally specific services for victims of  
498.22 labor trafficking or labor exploitation. This is  
498.23 a onetime appropriation.

498.24 **(cc) TANF Appropriations.** (1) TANF funds  
498.25 must be used as follows:

498.26 (i) \$3,579,000 in fiscal year 2024 and  
498.27 \$3,579,000 in fiscal year 2025 are from the  
498.28 TANF fund for home visiting and nutritional  
498.29 services listed under Minnesota Statutes,  
498.30 section 145.882, subdivision 7, clauses (6) and  
498.31 (7). Funds must be distributed to community  
498.32 health boards according to Minnesota Statutes,  
498.33 section 145A.131, subdivision 1;

499.1 (ii) \$2,000,000 in fiscal year 2024 and  
499.2 \$2,000,000 in fiscal year 2025 are from the  
499.3 TANF fund for decreasing racial and ethnic  
499.4 disparities in infant mortality rates under  
499.5 Minnesota Statutes, section 145.928,  
499.6 subdivision 7;

499.7 (iii) \$4,978,000 in fiscal year 2024 and  
499.8 \$4,978,000 in fiscal year 2025 are from the  
499.9 TANF fund for the family home visiting grant  
499.10 program under Minnesota Statutes, section  
499.11 145A.17. \$4,000,000 in each fiscal year must  
499.12 be distributed to community health boards  
499.13 under Minnesota Statutes, section 145A.131,  
499.14 subdivision 1. \$978,000 in each fiscal year  
499.15 must be distributed to Tribal governments  
499.16 under Minnesota Statutes, section 145A.14,  
499.17 subdivision 2a;

499.18 (iv) \$1,156,000 in fiscal year 2024 and  
499.19 \$1,156,000 in fiscal year 2025 are from the  
499.20 TANF fund for family planning grants under  
499.21 Minnesota Statutes, section 145.925; and

499.22 (v) the commissioner may use up to 6.23  
499.23 percent of the funds appropriated from the  
499.24 TANF fund each fiscal year to conduct the  
499.25 ongoing evaluations required under Minnesota  
499.26 Statutes, section 145A.17, subdivision 7, and  
499.27 training and technical assistance as required  
499.28 under Minnesota Statutes, section 145A.17,  
499.29 subdivisions 4 and 5.

499.30 **(2) TANF Carryforward.** Any unexpended  
499.31 balance of the TANF appropriation in the first  
499.32 year does not cancel but is available in the  
499.33 second year.

500.1 (dd) **Base Level Adjustments.** The general  
 500.2 fund base is \$193,750,000 in fiscal year 2026  
 500.3 and \$193,323,000 in fiscal year 2027. The  
 500.4 health care access fund base is \$42,157,000  
 500.5 in fiscal year 2026 and \$41,557,000 in fiscal  
 500.6 year 2027.

500.7 **Subd. 3. Health Protection**

500.8	<u>Appropriations by Fund</u>		
500.9	<u>General</u>	<u>36,608,000</u>	<u>32,585,000</u>
500.10	<u>State Government</u>		
500.11	<u>Special Revenue</u>	<u>70,981,000</u>	<u>73,220,000</u>

500.12 (a) **Lead Remediation in Schools and Child**  
 500.13 **Care Settings.** \$500,000 in fiscal year 2024  
 500.14 and \$500,000 in fiscal year 2025 are from the  
 500.15 general fund to reduce lead in drinking water  
 500.16 in schools and child care facilities under  
 500.17 Minnesota Statutes, section 145.9272. Of this  
 500.18 appropriation in fiscal year 2024, \$146,000 is  
 500.19 for grants and \$354,000 is for administration  
 500.20 and in fiscal year 2025, \$239,000 is for grants  
 500.21 and \$261,000 is for administration.

500.22 (b) **Antimicrobial Stewardship.** \$312,000 in  
 500.23 fiscal year 2024 and \$312,000 in fiscal year  
 500.24 2025 are from the general fund for the  
 500.25 Minnesota One Health Antimicrobial  
 500.26 Stewardship Collaborative under Minnesota  
 500.27 Statutes, section 144.0526.

500.28 (c) **Comprehensive Overdose and Morbidity**  
 500.29 **Prevention Act; Public Health Laboratory**  
 500.30 **and Infectious Disease Prevention.**  
 500.31 \$1,544,000 in fiscal year 2024 and \$1,544,000  
 500.32 in fiscal year 2025 are from the general fund  
 500.33 for comprehensive overdose and morbidity  
 500.34 prevention strategies under Minnesota  
 500.35 Statutes, section 144.0528. Of this

501.1 appropriation in fiscal year 2024, \$960,000 is  
 501.2 for grants and \$584,000 is for administration  
 501.3 and in fiscal year 2025, \$960,000 is for grants  
 501.4 and \$584,000 is for administration.

501.5 **(d) HIV Prevention Health Equity.**  
 501.6 \$2,267,000 in fiscal year 2024 and \$2,267,000  
 501.7 in fiscal year 2025 are from the general fund  
 501.8 for equity in HIV prevention. Of this  
 501.9 appropriation each year, \$1,264,000 is for  
 501.10 grants under Minnesota Statutes, section  
 501.11 145.924, and \$1,003,000 is for administration.  
 501.12 This is a onetime appropriation.

501.13 **(e) Uninsured and Underinsured Adult**  
 501.14 **Vaccine Program.** \$1,470,000 in fiscal year  
 501.15 2024 and \$1,470,000 in fiscal year 2025 are  
 501.16 from the general fund for the program for  
 501.17 vaccines for uninsured and underinsured  
 501.18 adults. This is a onetime appropriation.

501.19 **(f) Transfer to Public Health Response**  
 501.20 **Contingency Account.** The commissioner  
 501.21 shall transfer \$4,804,000 in fiscal year 2024  
 501.22 from the general fund to the public health  
 501.23 response contingency account established in  
 501.24 Minnesota Statutes, section 144.4199. This is  
 501.25 a onetime transfer.

501.26 **(g) Base Level Adjustments.** The general  
 501.27 fund base is \$31,115,000 in fiscal year 2026  
 501.28 and \$31,115,000 in fiscal year 2027.

501.29 **Subd. 4. Health Operations**

501.30	<u>Appropriations by Fund</u>		
501.31	<u>General</u>	<u>18,492,000</u>	<u>18,405,000</u>

501.32 **Sec. 4. HEALTH-RELATED BOARDS**

501.33	<u>Subdivision 1. Total Appropriation</u>	<u>\$</u>	<u>31,304,000</u>	<u>\$</u>	<u>32,040,000</u>
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502.1	<u>Appropriations by Fund</u>		
502.2	<u>General Fund</u>	<u>468,000</u>	<u>468,000</u>
502.3	<u>State Government</u>		
502.4	<u>Special Revenue</u>	<u>30,760,000</u>	<u>31,534,000</u>
502.5	<u>Health Care Access</u>	<u>76,000</u>	<u>38,000</u>
502.6	<u>This appropriation is from the state</u>		
502.7	<u>government special revenue fund unless</u>		
502.8	<u>specified otherwise. The amounts that may be</u>		
502.9	<u>spent for each purpose are specified in the</u>		
502.10	<u>following subdivisions.</u>		
502.11	<u>Subd. 2. Board of Behavioral Health and</u>		
502.12	<u>Therapy</u>	<u>1,022,000</u>	<u>1,044,000</u>
502.13	<u>Subd. 3. Board of Chiropractic Examiners</u>		
502.14	<u>Subd. 4. Board of Dentistry</u>		
502.15	<u>(a) Administrative Services Unit; Operating</u>		
502.16	<u>Costs. Of this appropriation, \$1,936,000 in</u>		
502.17	<u>fiscal year 2024 and \$1,960,000 in fiscal year</u>		
502.18	<u>2025 are for operating costs of the</u>		
502.19	<u>administrative services unit. The</u>		
502.20	<u>administrative services unit may receive and</u>		
502.21	<u>expend reimbursements for services it</u>		
502.22	<u>performs for other agencies.</u>		
502.23	<u>(b) Administrative Services Unit; Volunteer</u>		
502.24	<u>Health Care Provider Program. Of this</u>		
502.25	<u>appropriation, \$150,000 in fiscal year 2024</u>		
502.26	<u>and \$150,000 in fiscal year 2025 are to pay</u>		
502.27	<u>for medical professional liability coverage</u>		
502.28	<u>required under Minnesota Statutes, section</u>		
502.29	<u>214.40.</u>		
502.30	<u>(c) Administrative Services Unit;</u>		
502.31	<u>Retirement Costs. Of this appropriation,</u>		
502.32	<u>\$237,000 in fiscal year 2024 and \$237,000 in</u>		
502.33	<u>fiscal year 2025 are for the administrative</u>		
502.34	<u>services unit to pay for the retirement costs of</u>		
502.35	<u>health-related board employees. This funding</u>		

503.1 may be transferred to the health board  
 503.2 incurring retirement costs. Any board that has  
 503.3 an unexpended balance for an amount  
 503.4 transferred under this paragraph shall transfer  
 503.5 the unexpended amount to the administrative  
 503.6 services unit. If the amount appropriated in  
 503.7 the first year of the biennium is not sufficient,  
 503.8 the amount from the second year of the  
 503.9 biennium is available.

503.10 **(d) Administrative Services Unit; Contested**  
 503.11 **Cases and Other Legal Proceedings.** Of this  
 503.12 appropriation, \$200,000 in fiscal year 2024  
 503.13 and \$200,000 in fiscal year 2025 are for costs  
 503.14 of contested case hearings and other  
 503.15 unanticipated costs of legal proceedings  
 503.16 involving health-related boards funded under  
 503.17 this section. Upon certification by a  
 503.18 health-related board to the administrative  
 503.19 services unit that costs will be incurred and  
 503.20 that there is insufficient money available to  
 503.21 pay for the costs out of money currently  
 503.22 available to that board, the administrative  
 503.23 services unit is authorized to transfer money  
 503.24 from this appropriation to the board for  
 503.25 payment of those costs with the approval of  
 503.26 the commissioner of management and budget.  
 503.27 The commissioner of management and budget  
 503.28 must require any board that has an unexpended  
 503.29 balance for an amount transferred under this  
 503.30 paragraph to transfer the unexpended amount  
 503.31 to the administrative services unit to be  
 503.32 deposited in the state government special  
 503.33 revenue fund.

503.34 **Subd. 5. Board of Dietetics and Nutrition**  
 503.35 **Practice**

213,000

217,000

504.1	<b><u>Subd. 6. Board of Executives for Long-term</u></b>		
504.2	<b><u>Services and Supports</u></b>	<u>705,000</u>	<u>736,000</u>
504.3	<b><u>Subd. 7. Board of Marriage and Family Therapy</u></b>	<u>443,000</u>	<u>456,000</u>
504.4	<b><u>Subd. 8. Board of Medical Practice</u></b>	<u>5,779,000</u>	<u>5,971,000</u>
504.5	<b><u>Subd. 9. Board of Nursing</u></b>	<u>6,039,000</u>	<u>6,275,000</u>
504.6	<b><u>Subd. 10. Board of Occupational Therapy</u></b>		
504.7	<b><u>Practice</u></b>	<u>468,000</u>	<u>480,000</u>
504.8	<b><u>Subd. 11. Board of Optometry</u></b>	<u>270,000</u>	<u>280,000</u>
504.9	<b><u>Subd. 12. Board of Pharmacy</u></b>		
504.10	<u>Appropriations by Fund</u>		
504.11	<u>General Fund</u>	<u>468,000</u>	<u>468,000</u>
504.12	<u>State Government</u>		
504.13	<u>Special Revenue</u>	<u>5,226,000</u>	<u>5,206,000</u>
504.14	<u>Health Care Access</u>	<u>76,000</u>	<u>38,000</u>
504.15	<b><u>(a) Medication Repository Program.</u></b>		
504.16	<u>\$468,000 in fiscal year 2024 and \$468,000 in</u>		
504.17	<u>fiscal year 2025 are from the general fund for</u>		
504.18	<u>transfer to the central repository to administer</u>		
504.19	<u>the medication repository program under</u>		
504.20	<u>Minnesota Statutes, section 151.555.</u>		
504.21	<b><u>(b) Base Level Adjustment.</u></b> The state		
504.22	<u>government special revenue fund base is</u>		
504.23	<u>\$5,056,000 in fiscal year 2026 and \$5,056,000</u>		
504.24	<u>in fiscal year 2027. The health care access</u>		
504.25	<u>fund base is \$0 in fiscal year 2026 and \$0 in</u>		
504.26	<u>fiscal year 2027.</u>		
504.27	<b><u>Subd. 13. Board of Physical Therapy</u></b>	<u>678,000</u>	<u>694,000</u>
504.28	<b><u>Subd. 14. Board of Podiatric Medicine</u></b>	<u>253,000</u>	<u>257,000</u>
504.29	<b><u>Subd. 15. Board of Psychology</u></b>	<u>2,618,000</u>	<u>2,734,000</u>
504.30	<b><u>Health Professionals Service Program. This</u></b>		
504.31	<u>appropriation includes \$1,234,000 in fiscal</u>		
504.32	<u>year 2024 and \$1,324,000 in fiscal year 2025</u>		
504.33	<u>for the health professional services program.</u>		

505.1	<u>Subd. 16. Board of Social Work</u>	<u>1,779,000</u>	<u>1,839,000</u>
505.2	<u>Subd. 17. Board of Veterinary Medicine</u>	<u>382,000</u>	<u>392,000</u>
505.3	<u>Sec. 5. EMERGENCY MEDICAL SERVICES</u>		
505.4	<u>REGULATORY BOARD</u>	<u>\$ 6,800,000</u>	<u>\$ 6,176,000</u>
505.5	<u>(a) Cooper/Sams Volunteer Ambulance</u>		
505.6	<u>Program. \$950,000 in fiscal year 2024 and</u>		
505.7	<u>\$950,000 in fiscal year 2025 are for the</u>		
505.8	<u>Cooper/Sams volunteer ambulance program</u>		
505.9	<u>under Minnesota Statutes, section 144E.40.</u>		
505.10	<u>(1) Of this appropriation, \$861,000 in fiscal</u>		
505.11	<u>year 2024 and \$861,000 in fiscal year 2025</u>		
505.12	<u>are for the ambulance service personnel</u>		
505.13	<u>longevity award and incentive program under</u>		
505.14	<u>Minnesota Statutes, section 144E.40.</u>		
505.15	<u>(2) Of this appropriation, \$89,000 in fiscal</u>		
505.16	<u>year 2024 and \$89,000 in fiscal year 2025 are</u>		
505.17	<u>for operations of the ambulance service</u>		
505.18	<u>personnel longevity award and incentive</u>		
505.19	<u>program under Minnesota Statutes, section</u>		
505.20	<u>144E.40.</u>		
505.21	<u>(b) EMSRB Operations. \$2,421,000 in fiscal</u>		
505.22	<u>year 2024 and \$2,480,000 in fiscal year 2025</u>		
505.23	<u>are for board operations.</u>		
505.24	<u>(c) Regional Grants for Continuing</u>		
505.25	<u>Education. \$585,000 in fiscal year 2024 and</u>		
505.26	<u>\$585,000 in fiscal year 2025 are for regional</u>		
505.27	<u>emergency medical services programs to be</u>		
505.28	<u>distributed equally to the eight emergency</u>		
505.29	<u>medical service regions under Minnesota</u>		
505.30	<u>Statutes, section 144E.52.</u>		
505.31	<u>(d) Ambulance Training Grants. \$361,000</u>		
505.32	<u>in fiscal year 2024 and \$361,000 in fiscal year</u>		
505.33	<u>2025 are for training grants under Minnesota</u>		
505.34	<u>Statutes, section 144E.35.</u>		

506.1 **(e) Medical Resource Communication**  
 506.2 **Center Grants.** \$1,683,000 in fiscal year 2024  
 506.3 and \$1,000,000 in fiscal year 2025 are for  
 506.4 medical resource communication center grants  
 506.5 under Minnesota Statutes, section 144E.53.  
 506.6 This is a onetime appropriation.

506.7 **(f) Grants to Regional Emergency Medical**  
 506.8 **Services Program.** \$800,000 in fiscal year  
 506.9 2024 and \$800,000 in fiscal year 2025 are for  
 506.10 grants to regional emergency medical services  
 506.11 programs, to be distributed among the eight  
 506.12 emergency medical services regions according  
 506.13 to Minnesota Statutes, section 144E.50.

506.14 **(g) Base Level Adjustment.** The general fund  
 506.15 base is \$5,176,000 in fiscal year 2026 and  
 506.16 \$5,176,000 in fiscal year 2027.

506.17 **Sec. 6. MNSURE.** **\$ 22,373,000 \$ 34,810,000**

506.18 **(a) Transfer.** The general fund appropriations  
 506.19 must be transferred to the enterprise account  
 506.20 established under Minnesota Statutes, section  
 506.21 62V.07, for the purpose of establishing a  
 506.22 single end-to-end IT system with seamless,  
 506.23 real-time interoperability between qualified  
 506.24 health plan eligibility and enrollment services.

506.25 **(b) Base Level Adjustment.** The general fund  
 506.26 base is \$3,591,000 in fiscal year 2026,  
 506.27 \$3,530,000 in fiscal year 2027, and \$7,055,000  
 506.28 in fiscal year 2028.

506.29 **Sec. 7. RARE DISEASE ADVISORY**  
 506.30 **COUNCIL** **\$ 314,000 \$ 326,000**

507.1 Sec. 8. Laws 2021, First Special Session chapter 7, article 16, section 2, subdivision 32,  
 507.2 as amended by Laws 2022, chapter 98, article 15, section 7, subdivision 32, is amended to  
 507.3 read:

507.4 Subd. 32. **Grant Programs; Child Mental Health**  
 507.5 **Grants** 30,167,000 30,182,000

507.6 (a) **Children's Residential Facilities.**

507.7 \$1,964,000 in fiscal year 2022 and \$1,979,000  
 507.8 in fiscal year 2023 are to reimburse counties  
 507.9 and Tribal governments for a portion of the  
 507.10 costs of treatment in children's residential  
 507.11 facilities. The commissioner shall distribute  
 507.12 the appropriation to counties and Tribal  
 507.13 governments proportionally based on a  
 507.14 methodology developed by the commissioner.  
 507.15 ~~The fiscal year 2022 appropriation is available~~  
 507.16 ~~until June 30, 2023~~ base for this activity is \$0  
 507.17 in fiscal year 2025.

507.18 (b) **Base Level Adjustment.** The general fund  
 507.19 base is \$29,580,000 in fiscal year 2024 and  
 507.20 ~~\$27,705,000~~ \$25,726,000 in fiscal year 2025.

507.21 Sec. 9. **ASSET DISREGARDS.**

507.22 \$351,000 in fiscal year 2023 is appropriated from the general fund to the commissioner  
 507.23 of human services to implement a temporary asset disregard program in the medical  
 507.24 assistance program. This is a onetime appropriation.

507.25 Sec. 10. **TRANSFERS.**

507.26 Subdivision 1. **Grants.** The commissioner of human services, with the approval of the  
 507.27 commissioner of management and budget, may transfer unencumbered appropriation balances  
 507.28 for the biennium ending June 30, 2025, within fiscal years among the MFIP; general  
 507.29 assistance; medical assistance; MinnesotaCare; MFIP child care assistance under Minnesota  
 507.30 Statutes, section 119B.05; Minnesota supplemental aid program; housing support program;  
 507.31 the entitlement portion of Northstar Care for Children under Minnesota Statutes, chapter  
 507.32 256N; and the entitlement portion of the behavioral health fund between fiscal years of the  
 507.33 biennium. The commissioner shall inform the chairs and ranking minority members of the

508.1 legislative committees with jurisdiction over health and human services quarterly about  
508.2 transfers made under this subdivision.

508.3 Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money  
508.4 may be transferred within the Department of Human Services as the commissioners consider  
508.5 necessary, with the advance approval of the commissioner of management and budget. The  
508.6 commissioners shall inform the chairs and ranking minority members of the legislative  
508.7 committees with jurisdiction over health and human services finance quarterly about transfers  
508.8 made under this section.

508.9 **Sec. 11. TRANSFERS; ADMINISTRATION.**

508.10 Positions, salary money, and nonsalary administrative money may be transferred within  
508.11 the Department of Health as the commissioner considers necessary with the advance approval  
508.12 of the commissioner of management and budget. The commissioner shall inform the chairs  
508.13 and ranking minority members of the legislative committees with jurisdiction over health  
508.14 finance quarterly about transfers made under this section.

508.15 **Sec. 12. INDIRECT COSTS NOT TO FUND PROGRAMS.**

508.16 The commissioner of health shall not use indirect cost allocations to pay for the  
508.17 operational costs of any program for which they are responsible.

508.18 **Sec. 13. APPROPRIATIONS GIVEN EFFECT ONCE.**

508.19 If an appropriation or transfer in this article is enacted more than once during the 2023  
508.20 regular session, the appropriation or transfer must be given effect once.

508.21 **Sec. 14. EXPIRATION OF UNCODIFIED LANGUAGE.**

508.22 All uncodified language contained in this article expires on June 30, 2025, unless a  
508.23 different expiration date is explicit."

508.24 Amend the title accordingly